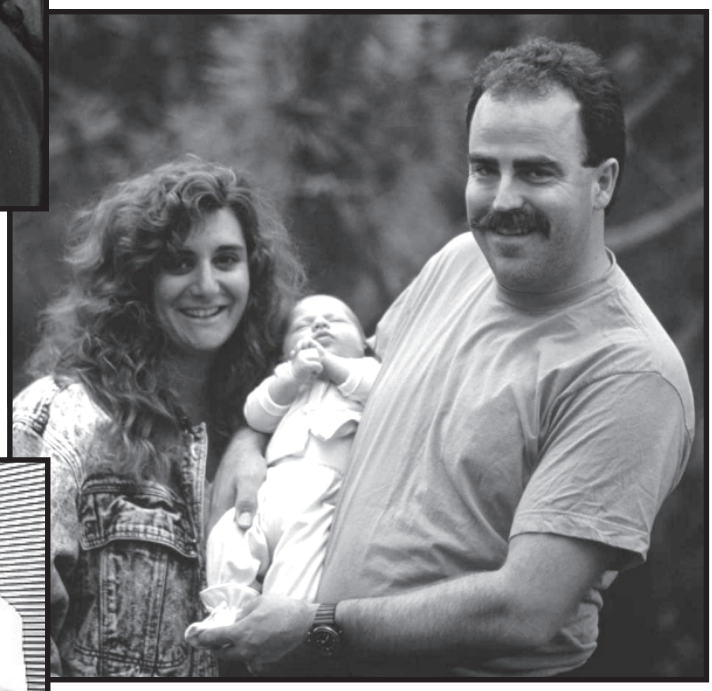
KNOW YOUR BENEFITS

2003 MARICOPA COUNTY EMPLOYEE BENEFITS GUIDE



Maricopa County

The information in this booklet highlights Maricopa County's benefits program for employees and their dependents.

It is intended to be a guide to help you make important decisions. The benefits described are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Maricopa County reserves the right to change or cancel any of its plans, in whole or in part, at any time.

Participation in any of the County's benefit plans is not a contract of employment.

HOW TO OBTAIN BENEFIT INFORMATION

Information about the benefits plan is available on the **Internet at www.maricopa.gov/benefits,** or **EBC/Intranet at ebc.maricopa.gov/hr/benefits.**

(Both of these web sites are collectively referred to as the "Benefits Home Page" in this document.)

You may also e-mail the Benefits Office at benefitsservice@mail.maricopa.gov or call them for plan information at 602-506-1010, Monday through Friday, 8:00 AM - 5:00 PM MST.

The Benefits Office can assist you with general benefit information, enrollment, and qualified status changes, premium questions, benefit continuation while on leave of absence, and/or when you retire.

Please contact the specific vendor for detailed benefit questions regarding coverage, costs, and claims payment. Vendor contact information is located in the *Who to Contact* section of this guide.

When the words "you" or "your" are used in this document, they refer to the employee. When the word "we" is used in this document, it refers to Maricopa County. When the words "benefits plan" or "plan" are used in this document, they refer to the Maricopa County Employee Benefits Plan. The term "Benefits Office" refers to the Maricopa County Employee Benefits Office.

Areas highlighted in gray are new or updated in this version of the document.

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INTRODUCTION

Maricopa County recognizes your valuable contributions as an employee by offering comprehensive benefits for you and your dependents through the Employee Benefits Plan. Maricopa County is committed to helping you deal with the high costs of healthcare, the risks of lost income due to illness and disability, and to help you prepare for a secure retirement.

The County's benefits plan provides:

- A choice of Medical Plans: HealthSelect or CIGNA;
- A Vision Benefit;
- Behavioral Health and Substance Abuse Services;
- An Employee Assistance Plan;
- A choice of Dental Benefits;
- Basic Life, Accidental Death and Dismemberment, and Supplemental Life Insurance Benefits;
- Short Term Disability Coverage;
- Health and Dependent Care Flexible Spending Accounts (Mariflex);
- A Deferred Compensation Plan;
- Discounts on Auto, Home, and Renters Insurance;
- Critical Illness Coverage; and
- Arizona State Retirement System benefits, which includes a Long-term Disability program, or Public Safety Personnel Retirement System benefits. Please visit www.asrs.state.az.us or www.psprs.com for details.

WHO'S ELIGIBLE?

You can participate in the Benefits plan if you are a regular employee scheduled to work at least 40 hours per pay period (50%-100% of full-time).

"Regular employee" means you are either a full-time or a part-time employee, and does not include temporary employees. Employees working under specific contracts may or may not be eligible for certain benefits according to the terms of their contract. Each appointing authority, in conjunction with the Total Compensation Department, determines if contracted employees are benefits eligible.

Temporary employees and those regular employees who are scheduled to work less than 40 hours per pay period (less than 50%) are not eligible to participate in the benefits described in this booklet.

ARE DEPENDENTS ELIGIBLE?

Your legal spouse and/or your unmarried dependent child(ren) are eligible to be covered if the dependent meets the definition, conditions, and limitations of a child and dependent.

The term "child" means your unmarried natural child, stepchild, legally adopted child, a child placed with you for adoption, or a child for whom you have been awarded legal guardianship. The term "dependent" means a child meeting one of the relationships listed above, who resides with you, or is temporarily absent due to school attendance.

The definition of dependent is subject to one of the following:

- Your unmarried dependent child(ren) under 19 years of age.
- Your unmarried dependent child(ren) who is 19 years of age or older, but less than 25 years of age, if he/she is not regularly employed on a full-time basis, is a full-time student (as defined by the school) at an accredited institution of higher education, and is dependent upon you for support and maintenance. (You must provide more than half of his/her support according to the Internal Revenue Code (IRC) Section 152.) Your student dependent will remain eligible during summer breaks from school as long as he/she will be attending school on a full-time basis for the fall term/semester.
- Your unmarried child, of any age, who resides with you and who is medically certified as disabled prior to his/her 19th birthday, and who is primarily dependent upon you for support and maintenance.
- Your child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order(s) - even if he/she does not reside with you. Copies of the applicable pages of the support order are required for documentation.

You may be asked from time to time by the Benefits Office or the vendor to provide verification of dependent eligibility. However, it is your responsibility to immediately notify the Benefits Office when your dependent becomes ineligible for coverage. You will be liable for the costs of all services covered under the Benefits plan for your dependent who is ineligible on the date of service.

WHEN DOES COVERAGE BEGIN?

You have 60 calendar days from your hire date to elect and submit your enrollment form with your benefit elections through your Department's Human Resource (HR) Liaison or directly to the Maricopa County Employee Benefits Office. Benefits (and applicable premiums) start the first day of the pay period following 14 calendar days after a completed enrollment form is received by the Benefits Office or your HR Liaison. You may designate a later effective date at the time you submit your enrollment form, if it is within 60 calendar days of your hire date and is consistent with the first day of a pay period.

If a completed enrollment form is not received within 60 calendar days of employment, your medical coverage will default to HealthSelect with single coverage for yourself and basic life insurance (one times your annual salary rounded up to the next thousand). To prevent a delay in your coverage and preserve your choice of plans, the enrollment form should be completed and turned in as soon as possible.

After benefit elections have been submitted to the Benefits Office, no change in benefits will be allowed until the next open enrollment period, unless you have a qualified status change as defined under IRC Section 125. Refer to the following sections in this booklet for more information: *When Can You Make Changes?* and *What is a Qualified Status Change?*

Open Enrollment occurs each year, generally in late October through early November for a January 1 effective date. Open Enrollment dates are advertised on the EBC Intranet and communicated to each Department. Please check with your Department Payroll, HR Liaison, or Employee Benefits Advisory Committee (EBAC) member or the Benefits Office to find out the exact dates of the next Open Enrollment period. A listing of HR Liaisons and EBAC members is available on the Benefits Home Page.

HOW TO ENROLL

You should attend a New Employee Orientation (NEO) meeting to receive benefits plan information. You can complete and submit your enrollment form at this meeting or at a later date. It is to your benefit to complete and submit your enrollment forms as soon as possible. Refer to section *When Does Coverage Begin* for more information.

If you are not scheduled to attend a NEO meeting, you have the following additional options:

- Ask your HR Liaison for the enrollment materials.
- Go online to the Benefits Home Page to obtain benefits plan information and enrollment forms you need to make your coverage choices.
  - The Intranet/EBC address is: **http://ebc.maricopa.gov/hr/benefits/**
  - The Internet address is: **http://www.maricopa.gov/benefits/**
- Contact the Benefits Office via e-mail at benefitsservice@mail.maricopa.gov. via the Internet, or the Microsoft Outlook Global address list.
- Call the Benefits Office for information at 602-506-1010.
- Visit the Benefits Office located at 301 W. Jefferson, Suite 201, Phoenix, AZ, 85003.

WHO PAYS FOR MEDICAL COVERAGE?

EMPLOYER CONTRIBUTION

You have the option to select medical coverage from two vendors: HealthSelect or CIGNA. These medical plans are described in the section *Medical Plans*. This section discusses how Maricopa County contributes towards the cost of the medical plans.

If you work full-time (60 or more hours per pay period), you will receive the maximum, full-time County contribution towards your premium for either the HealthSelect or the CIGNA medical benefit plans for you and your dependents.

If you work **part-time** (40 to 59 hours per pay period) and enroll with **HealthSelect,** you will receive the **maximum, full-time County contribution** towards your premium for the HealthSelect medical benefit plan for you and your dependents. If you select this advantageous option, your premiums will be the same as those of a full-time employee.

If you work **part-time** (40 to 59 hours per pay period) and enroll with **CIGNA**, you will receive a **lower County contribution** towards your premium for the CIGNA medical benefit plan for you and your dependents. This means you will pay more in your premiums for the CIGNA medical benefit plan than an employee who works full-time and selects CIGNA or an employee who works part-time and chooses HealthSelect.

EMPLOYEE CONTRIBUTION

When you elect your coverage, you authorize the County to collect the current employee benefit premiums from your paycheck for each benefit option. You share the responsibility with the Benefits Office to ensure your benefit premiums that are deducted from your paycheck are accurate. You are responsible to review your paycheck stub to verify that correct premium deduction amounts are taken for the benefit options you elected. Please refer to the premium rates in the *2003 Premium Rates* section.

If the premium deductions on your paycheck are incorrect in that you have been charged a higher amount due to an administrative error, and you identify the problem in writing to the Benefits Office within six (6) months from the date the error began, your premiums and claims will be adjusted to reflect the correct amounts from the date of the error. If your premium deduction is incorrect in that you have been charged a lower amount than you should have paid, your premiums and claims will be adjusted retroactively to the date of the occurrence and you will be responsible for the full cost of the underpaid premiums.

Deductions for the medical, dental, and healthcare and/or dependent care flexible spending accounts (Mariflex) reduce your taxable income, and therefore save taxes you would otherwise pay. The tax savings reduce the cost of your benefits. This tax advantage is provided under and follows the rules of IRC Section 125.

WAIVER OF MEDICAL INSURANCE

The County will compensate you a total of $75.00 per month if you are scheduled to work at least 60 hours per pay period and waive medical coverage in lieu of other group insurance coverage. Waiving medical coverage means that you are waiving coverage for all components of the medical plan, which includes medical, vision, prescription, and behavioral health and substance abuse benefits. This compensation will be remitted in your bi-weekly paycheck from the County. You are required to provide proof of other group medical insurance coverage. Election of a waiver of medical insurance may only be done during the new hire election period, within 31 days of either a family status change or becoming eligible for the waiver (i.e., going from being scheduled to work less than 60 hours per pay period to 60 or more hours per pay period), or during open enrollment. Medical waiver payments are suspended while you are on an unpaid leave of absence.

DO BENEFITS CONTINUE WHILE ON A LEAVE OF ABSENCE?

The maximum period of time the County will continue its contribution towards your premiums for you and your dependents while you are on an approved personal leave of absence is 90 calendar days commencing with the first day of your unpaid leave.

The maximum period of time the County will continue its contribution towards your premiums for you and your dependents while you are on an approved FMLA (Family Medical Leave Act) or non-FMLA medical leave of absence is 180 calendar days commencing with the first day of your unpaid leave. Personal leave and medical leave may not be combined to increase the 180 day maximum.

The maximum period of time the County will continue its contribution towards your premiums for you and your dependents while you are on a military leave of absence is one year commencing with the first day of your unpaid leave.

You must continue to pay your portion of the insurance premium in order for benefits to continue. Non-payment of your portion of the premium will result in coverage cancellation effective the last day of the pay period in which you paid your portion of the premium.

A written agreement with the Benefits Office must be made in advance of your leave, if possible, regarding premium payment and coverage options while you are on an approved leave of absence. If advance notice is not possible due to your medical condition or other extenuating circumstance, the agreement must be made as soon as practicable to avoid coverage cancellation.

Coverage options available during a leave of absence include revocation of coverage, or continuation of coverage with pre-payment or pay as you go (every two weeks).

If coverage is cancelled as a result of your non-payment of premium during your leave of absence, your coverage may be reinstated with no waiting period upon your return to a benefit eligible active employment status with Maricopa County.

Medical waiver payment is suspended for eligible employees during an unpaid leave of absence.

WHEN DOES COVERAGE END?

Coverage ends the last day of the payroll period in which you and/or your covered dependents cease to be eligible for coverage and for which a premium was paid, whichever comes first. (Refer to *Who's Eligible?* and *Do Benefits Continue While On A Leave of Absence?* sections.)

EXCEPTIONS

- Dependent spouse and stepchildren coverage ends on the date of divorce.
- Dependent child coverage ends the date the child loses dependent status either due to reaching an age limitation, ending attendance in an institution of higher education, marriage, changing to a different residence than yours, ending of a support order, or changing in support requirements (i.e., no longer primarily dependent upon you for more than 50 percent of his/her support).

You are responsible for immediately notifying the Benefits Office when a dependent no longer meets the eligibility requirements listed in the *Are Dependents Covered?* section. Medical, other benefit expenses, and administrative costs paid or incurred on behalf of an ineligible dependent become your liability.

WHEN CAN CHANGES BE MADE?

You can revoke a benefit election during the plan year and make a new election, if the revocation is due to a qualified status change and consistent with the status change as defined under IRC Section 125. Benefit election changes are consistent with status changes only if the election changes are necessary or appropriate because of the status change.

If you have a qualified status change any time during the year, you can change the level of your coverage (for example, from Employee Only to Employee and Family) if you notify the Benefits Office or your HR Liaison within 31 calendar days of the event by submitting an enrollment/change form and attaching appropriate third party documentation of the event. You cannot switch from one plan to another unless the change is consistent with the qualified status change. Retroactive changes will not be allowed unless otherwise required by law. Special rules apply to life insurance and short-term disability. (See the *Life Insurance Plan* and *Short-Term Disability Benefits* sections of the guide for details.)

In accordance with ARS 20-1057 B, if your medical coverage is under the CIGNA HMO or the Prime Option POS plan, coverage of a newborn child or a child placed for adoption will be effective from the date of birth or placement and will continue for the following 30 days if you are the primary insured according to Coordination of Benefits NAIC rules. In order for medical coverage to continue past the initial 31 days, you may be required to pay additional premium (i.e., if you are paying the employee only or employee and spouse premium instead of employee and family or employee and child). In order to properly administer the enrollment of the newborn in both the CIGNA medical plan and the WHI pharmacy plan, you must notify the Benefits Office or your HR Liaison of your status change by completing and submitting an enrollment/change form and attaching the appropriate documentation. The form must be submitted within 31 days of the change, if you are not paying the employee and family or employee and child premium. If you fail to submit your form and documentation within the appropriate timeframe, your newborn will not be covered after the initial 31 days.

WHAT IS A QUALIFIED STATUS CHANGE?

Examples of Qualified Status Changes as permitted by IRC Section 125 are listed below:

1. Leave under the Family Medical Leave Act (FMLA).
2. Judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order that requires accident or health coverage for an employee's child.
3. Entitlement or loss of entitlement of Medicare or Medicaid.

4. Change in Status:
    a. Events that change an employee's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; or annulment.
    b. Events that change an employee's number of dependents, including the following: birth; death; adoption; and placement for adoption. In the case of dependent care spending account, a change in the number of qualifying individuals as defined in IRC section 21 (b)(1).
    c. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent.
        - A termination or commencement of employment.
        - A strike or lockout.
        - A commencement of or return from an unpaid leave of absence.
        - A change in residence or worksite where eligibility no longer exists for the plan originally selected.
5. Dependent satisfies or ceases to satisfy eligibility requirements because of attainment of age, student status, or any similar circumstance.
6. A change in the place of residence of the employee, spouse, or dependent.
7. Significant cost or coverage changes.

HIPAA PRIVACY NOTICES

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator of your benefits plan, makes available a notice setting forth its privacy practices through the Electronic Business Center (EBC), on the Benefits Home page, through the HIPAA link. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights, and the plan's legal duties with respect to PHI.

SHARING OF YOUR PROTECTED HEALTH INFORMATION

Your and your dependents' protected health information will be shared with specific benefit plan representatives and others for the purposes of your health care treatment, for payment for that treatment, and for health care operations (as defined in the Health Insurance Portability and Accountability Act of 1996, as amended) of Maricopa County and of the Benefits plan vendors, as well as for other purposes allowed or required by law. When you submit your enrollment application, make an open enrollment change, or continue with your current coverage, you are acknowledging and accepting that Maricopa County and your health care providers, which could include CIGNA, HealthSelect, Walgreens Health Initiatives (WHI), United Behavioral Health (UBH), United Concordia, Employers Dental Service (EDS), UnumProvident, Avesis, ASI (the Mariflex Administrator), and ComPsych (the Employee Assistance Plan Administrator), and WHI in its role as Pharmacy Benefits Manager, may share medical information and administrative information concerning you and your dependents. By participating in the Benefits plan, you are releasing Maricopa County and Maricopa County's health care providers from any liability for any good faith release of protected health information pursuant to this acknowledgement.

NOTICE REGARDING USE OF YOUR SOCIAL SECURITY NUMBER

Disclosure of your Social Security Number (SSN) for purposes of open enrollment and other benefits related purposes is voluntary; there is no statutory or other authority requiring such disclosure. Your SSN is transmitted to the benefit plan vendors for administrative purposes. Most vendors use your SSN as your benefit identification (ID) number for the provision of health care benefits.

ALTERNATIVE ID NUMBERS

Your Social Security Number (SSN) is transmitted to the benefit plan vendors for administrative purposes. Most vendors use your SSN as your benefit identification (ID) number for the provision of health care benefits. Use of your SSN is voluntary; there is no statutory or other authority requiring such disclosure. If you do not want your SSN disclosed and used as your identifier with benefit plan vendors, you may request an alternative ID number by indicating your request on the enrollment/change form or by writing to the Benefits Office. The Benefits Office will arrange for each vendor you specified in your written request to assign an alternative ID number for you and your dependents. Each vendor has business rules on how they assign such numbers and there is no guarantee that

your alternative ID number will be the same for each of your benefit choices. Once the vendor assigns an alternative ID number, you and your dependents will not be able to be identified by your SSN. It is your responsibility to advise each of your providers that you have an alternative ID number when you access services so that your claims will process under your newly assigned ID number.

MEDICAL PLANS

• *HEALTHSELECT - A MANAGED CARE PRODUCT ADMINISTERED BY MARICOPA INTEGRATED HEALTH SYSTEM*

HealthSelect offers comprehensive healthcare benefits with low premiums and low copayments. The plan also offers many enhanced benefits and a large network of physician and hospital providers.

The HealthSelect product is a Primary Care Physician (PCP) based plan requiring you to choose a PCP who practices in one of the 12 Family Health Care facilities or in a private practice office. Your PCP will deliver your primary care and coordinate your specialty care through referrals. Certain services require pre-certification. Members must receive all non-emergency care from HealthSelect network providers, including physicians, hospitals, pharmacies, and/or ancillary providers. However, members are covered for emergency care, anywhere in the world. Non-emergency covered services are available within the service area of Maricopa County.

Your premium for the HealthSelect medical product includes additional coverage for pharmacy, behavioral health and substance abuse, and vision services. HealthSelect provides the medical and pharmacy coverage. United Behavioral Health provides the behavioral health and substance abuse coverage. The vision coverage is provided by Avesis. Please refer to the *Behavioral Health and Substance Abuse Services* and *Vision Benefit* sections of this booklet for details on those benefits.

PHYSICIAN AND HOSPITAL NETWORK

A network of over 350 physicians throughout Maricopa County in Family Health Centers and private physician offices offers you a variety of choices. The plan contracts with 15 hospitals in Maricopa County. There are 12 Family Health Centers (FHCs) offering comprehensive health care and many have in-house pharmacies for your convenience. Several FHCs offer extended hours on weekdays and Saturdays. These locations are in the East, West, and Central Valley and include the Chandler FHC, the Scottsdale FHC, the Seventh Avenue FHC and the Glendale FHC.

COPAYMENTS FOR MEDICAL VISITS AND PRESCRIPTIONS

Primary care and specialty care physician office visits, urgent care visits, and outpatient therapy/rehabilitation visits have a $5 copayment. The copayment for a hospital emergency department visit is $50; the copayment is waived if you are admitted to the hospital.

Prescription drug copayments are $5 for generic prescriptions (on formulary) and $15 for brand name prescriptions (on formulary) of up to a 30-day supply. These copayments apply to HealthSelect's contracted network of retail pharmacies (Fry's Food Stores and United Drugs) and the pharmacies in the Family Health Centers.

PRESCRIPTION HOME DELIVERY SERVICE

Home delivery of up to a 90-day supply of maintenance medications (on formulary) can be arranged through Fry's Food Store pharmacies, United Drug pharmacies, and the FHC pharmacies, including the Comprehensive Healthcare Center on 24th Street and Roosevelt in Phoenix. With this service, prescriptions are delivered to your home (within Maricopa County) for a copayment of $15 for generics and $30 for brand name prescriptions.

CHIROPRACTIC VISITS

Twelve visits per year are covered, with a copayment of $10 per visit. There is no prior authorization or PCP referral needed to access this benefit. Chiropractors in the HealthSelect Network must be used when accessing this benefit.

ALTERNATIVE MEDICINE

Six alternative medicine visits per year are covered, with a copayment of $5 per visit and a credit of $60 for supplements prescribed by the alternative medicine provider. Providers in the designated HealthSelect Alternative Medicine Network must be used when accessing this benefit. Alternative Medicine Supplies must be ordered by the contracted alternative medicine provider. Members must send a copy of the doctor's order/prescription along with the paid receipt for the supply item(s) to MIHS Customer Service in order to be reimbursed.

The Alternative Medicine benefits include:

- Acupuncture
- Homeopathy and Osteopathic Manipulation
- Craniosacral Therapy

DIRECT ACCESS TO SELECTED SPECIALISTS

HealthSelect members may self-refer or visit any family practice, internal medicine, pediatric, or OB/GYN physician within the HealthSelect Network without a referral from their primary care provider or prior authorization from the medical plan.

NO PRE-EXISTING CONDITION LIMITATION OR DEDUCTIBLE TO MEET

There is no pre-existing condition limitation or deductible to meet.

WELLNESS INCENTIVES

Family wellness is a major focus of the HealthSelect plan. When you participate in maintaining your good health, you are eligible to receive wellness incentives from the plan.

- **Health club (workout) incentive.** $75 payment every six months for active use of a health club. You have the health club staff note attendance on a certificate to provide proof of eight workouts completed per month for a six-month period.
- **Health screenings.** $30 variety store gift certificate for completion of mammograms for women over age 40; pap smear tests for women age 18 and older, and physical exams for men (age 40 and over).
- **Children's immunizations.** $30 variety store gift certificate for up-to-date childhood immunizations for children age 0-5.
- **Smoking cessation class, diabetic education program, or other health education program.** $30 variety store gift certificate for successful completion of a health education or smoking cessation class.

ADDITIONAL BENEFITS

- Reimbursement of up to $125 per semester towards the premium for student health insurance for out-of-area students
- Lasik eye surgery (discounted price of $875 per eye) at contracted provider
- $50 hearing aid allowance

THE HEALTHSELECT MEDICAL PLAN INCLUDES THE FOLLOWING BENEFITS

Pharmacy Benefit	Covered by HealthSelect.
Behavioral Health Benefit	Covered by United Behavioral Health. See *Behavioral Health and Substance Abuse Services* section of this booklet for benefit details.
Vision Benefit	Covered by Avesis. See *Vision* section of this booklet for benefit details.

Please contact the appropriate vendor if you have questions about the pharmacy, behavioral health, or vision benefit after reading the specific benefit sections in this booklet.

This is a brief summary of your benefits. For more information regarding your medical coverage or pharmacy benefit, please contact the HealthSelect Customer Service Department, Monday through Friday, 8:00 AM - 5:00 PM MST at 602-344-8760.

You are expected to receive urgent care from your primary care physician Monday through Friday, from 8:00 a.m. to 5:00 p.m. If your PCP is unable to see you, and your medical need is urgent, you can receive urgent care at one of the Family Health Centers that has extended hours or participating urgent care facilities. Or you may call the Prior Authorization Unit at 602-344-8811 or 1-800-552-8808 for advice. A listing of urgent care facilities is available on the HealthSelect link on the Benefits Home Page or on the Internet link listed below.

You should also refer to the HealthSelect Evidence of Coverage, Member Handbook, formulary list of approved drugs, and the provider directory on the Internet at http://www.maricopa.gov/medcenter/healthplans or via the Benefits Home Page.

HEALTHSELECT BENEFITS AT A GLANCE

	In-Network Charges/Costs
Standard Benefit Coverage	
Deductible	
Individual	None
Family	None
Standard Coinsurance Percentage Covered by Plan	
Out of Pocket Maximum for specific services	None
Individual	None
Family	None
Lifetime Maximum Benefit	Unlimited
Pre-existing Conditions	NA
General Services	
Preventive Care	$5 Copay
Primary Care Physician Services	$5 Copay
Specialty Care Physician Services	$5 Copay
Urgent Care Facility (Participating)	$5 Copay
Out-patient Lab and X-Ray	No Copay
In-patient Coverage	
Facility Charges	No Copay
Physician and Surgeon's Services	No Copay
Outpatient Surgery	No Copay
Non-certification Penalty	NA
Maternity	
Pre and Postnatal Exams (after pregnancy has been determined)	$5 Copay waived after initial visit
Delivery	No Copay
Emergency Care (Defined by Plan)	
Emergency Room - Copay waived if admitted	$50 Copay
Ambulance	No Copay
Equipment and Devices	
Durable Medical Equipment	No Copay
External Prosthetics and Orthotics	No Copay
Outpatient Rehabilitation	
Physical, Speech, and Occupational Therapy	$5 Copay
Chiropractic Services	$10 Copay, 12 Visits per year, Open Access, No referral required
Maximum Therapy and Chiropractic visits combined per year	60 Visits
Ancillary Benefits	
Vision and Hearing Screening	$5 Copay, $50 per year allowance for hearing aid
Other Healthcare Facilities	
Skilled Nursing Facilities	
Subscriber Payment	No Copay
Limit per Contract Year	20 days per illness
Home Health Care	No Copay when medically necessary (Unlimited)
Family Planning	
Sterilization: Vasectomy	Place of Service Copay
Sterilization: Tubal Ligation	Place of Service Copay
Infertility Treatment	Not Covered
Dependent Children	
Unmarried and legally dependent upon employee and/or spouse	Covered to age 19 unless full-time student and then covered to age 25 or if disabled
Pharmacy Benefit	**Covered by HealthSelect** **RETAIL:** $5.00 Copay for Generics / $15.00 Copay for Brand/30-day supply **MAIL ORDER:** $15 Copay for Generics / $30 Copay for Brand / 90-day supply
Behavioral Health Benefit	**Covered by United Behavioral Health. See *Behavioral Health and Substance Abuse Services* section for details.**
Vision Benefit	**Covered by Avesis. See *Vision* section for details.**

MEDICAL PLANS *(continued)*

• *CIGNA - ADMINISTERED BY CIGNA HEALTHCARE OF ARIZONA*

CIGNA offers three different medical plans with important benefit and cost differences based on freedom of choice, and use of health care delivery. The three plans available include a Health Maintenance Organization (HMO), Prime Option Point of Service (POS), and Preferred Provider Organization (PPO).

Your premium for the CIGNA medical plan you choose also includes other coverage for pharmacy, behavioral health and substance abuse, and vision. The medical coverage is provided by CIGNA. Walgreens Health Initiatives (WHI) administers your pharmacy coverage. United Behavioral Health provides the behavioral health and substance abuse coverage. The vision coverage is provided by Avesis. Please refer to *the Pharmacy Benefit for CIGNA Medical Plans, Behavioral Health and Substance Abuse Services,* and *Vision Benefit* sections of this booklet for details on these benefits.

CIGNA HMO CMG - A HEALTH MAINTENANCE ORGANIZATION (CIGNA MEDICAL GROUP)

GROUP NUMBER: See your ID card

The CIGNA HealthCare HMO plan offers quality health care at an affordable cost for you and your dependents. The HMO product is a Primary Care Physician (PCP) based plan requiring you to choose a PCP who practices in one of the 17 CIGNA Medical Group (HealthCare) facilities. Your PCP will deliver your primary care at one of the Medical Group facilities and coordinate your specialty care through referrals. Certain services require pre-certification. You must receive all non-emergency care through the HMO CIGNA Medical Group (CMG) network within the service area of Maricopa County. This includes physicians (PCPs at a Medical Group facility or specialists in private practice settings by PCP referral), hospitals, and/or ancillary providers. However, you are covered for emergency care anywhere in the world. Your selected PCP must be contracted with the CIGNA Medical Group network AZ812. Please use the provider directory titled CIGNA Medical Group. Or go online at www.cigna.com, select the provider directory link from the home page, enter your physician search requirements, select your benefit plan or program for primary care physician-based plans, and select the Healthplan network AZ Medical Group. **PCPs who practice in private offices are not included in this network.**

CIGNA HMO CMG Plan Highlights

- 17 Convenient Medical Group (HealthCare) facilities from which to access care
- Alternative Medicine Benefits
- 20 self-referred chiropractic visits to participating providers

CIGNA PRIME OPTION POS - A POINT OF SERVICE PRODUCT (PRIVATE PRACTICE PLAN)

GROUP NUMBER: See your ID card

The POS plan provides convenient, low-cost coverage in CIGNA's POS network… plus the option to go out of network for most services …at the point of service!

When you use your **in-network** benefits, the POS product operates as a Primary Care Physician (PCP) based plan where you must choose a primary care physician. Your PCP will deliver your primary care and coordinate your specialty care through referrals. Certain services require pre-certification. You must receive all non-emergency care through the POS Private Practice network within the service area of central and northern Arizona. This includes physicians, hospitals, and/or ancillary providers. However, you are covered for emergency care, anywhere in the world. Your selected PCP must be contracted with the CIGNA Healthcare of AZ network AZ801(also referred to as the Private Practice network.) Please use the provider directory titled CIGNA Healthcare of Arizona. Or go online at www.cigna.com, select the provider directory link from the home page, enter your physician search requirements, select your benefit plan or program for primary care physician-based plans, and select the Healthplan network AZ-Central and Northern.

This network includes the PCPs available in the CIGNA HMO plan, plus a wide selection of private practice doctors. Some PCPs may be in a smaller provider health organization network, which will limit other providers you may use. You pay a low out-of-pocket copayment for each in-network visit and there is no deductible.

NOTE: While the Prime Option POS in-network coverage has a $100 hospital copayment, this amount is reimbursable to you through Maricopa County. A Request for Reimbursement form (available from the Benefits Office or on the Benefits Home Page.) must be completed and submitted to the Benefits Office no later than six (6) months following the date of service. Requests submitted after this time period will be denied reimbursement.

When you wish, you can see any doctor of your choice without a referral or even if the doctor is not in CIGNA's POS Private Practice network or service area by using your **out-of-network** benefits. However, not all benefits are covered out-of-network. Certain services require pre-certification for which you will be responsible to obtain approval through CIGNA before using the services. The plan will reimburse your claims at 70% of the reasonable and customary (R&C) amount as defined by CIGNA, after meeting your calendar year deductible. If the provider charges a higher amount, you will be responsible for the excess charges (the difference between billed charges and R&C amounts). You will have to pay for services received, and then file a claim for reimbursement. Pre-existing limitations apply.

The Point of Service product gives you maximum savings when using in-network providers, and offers the flexibility and freedom of going outside the network as you wish.

CIGNA POS Plan Highlights

- In and out of network coverage
- Alternative Medicine Benefits
- 20 self-referred chiropractic visits to participating providers

CIGNA PPO - A PREFERRED PROVIDER ORGANIZATION PRODUCT

GROUP NUMBER: See your ID card

The PPO plan is a no-referral plan offering broad, open access to providers. This plan offers the highest degree of flexibility and freedom of choice.

As a PPO participant, you will have lower out-of-pocket expenses when you receive care **in-network** from participating CIGNA physicians in the PPO national network. Please use the provider directory titled PPO/PPA Preferred Provider Network. Or go online at www.cigna.com, select the provider directory link from the home page, enter your physician search requirements, and select your benefit plan or program for non-primary care based plans. You are not required to select a Primary Care Physician (PCP) and you can see any participating provider you chose, even a specialist. Certain services require pre-certification. You will be responsible for obtaining approval through CIGNA before using the services. The plan will reimburse your claims at 80% of the contracted amount. There are deductibles that apply to services, except when the service payment amount is a copayment (set dollar amount). Pre-existing limitations apply.

By utilizing your **out-of-network** benefits, you can choose to see non-participating doctors for care, but your benefits will be reduced and your out-of pocket costs will be higher. Not all benefits are available out-of-network. Certain services require pre-certification. You will be responsible for obtaining approval through CIGNA before using the services. The plan will reimburse your claim at 60% of the reasonable and customary (R&C) amount as defined by CIGNA, after meeting your calendar year deductible. If the provider charges a higher amount, you will be responsible for the excess charges (the difference between billed charges and R&C amounts). You will have to pay for services received, and then file a claim for reimbursement. Pre-existing limitations apply.

CIGNA PPO Plan Highlights

- In and out of network coverage
- No PCP or Referral
- Alternative Medicine Benefits

PRE-EXISTING LIMITATION

A Pre-existing condition is any illness or injury that is diagnosed or treated during a 90-day period immediately before your effective date of coverage under this plan. Pregnancy and genetic information with no related treatment are not considered pre-existing conditions. A child who is covered within 30 days of date of birth, adoption, or placement for adoption is not subject to the pre-existing limitations.

Under the Health Insurance Portability and Accountability Act (HIPAA), you will receive credit toward a pre-existing waiting period for any group health care coverage you had. You must provide a certificate of creditable coverage from your previous employer or insurance carrier which documents there was no more than a 63-day period between termination of your prior health coverage and employment with the County. Covered expenses will not include, and no payment will be made for, expenses incurred for or in connection with an injury or sickness which is a pre-existing condition, unless those conditions are incurred after a continuous one-year period

during which a person is satisfying a waiting period and/or is insured for these benefits.

ALL CIGNA MEDICAL PRODUCTS INCLUDE THE FOLLOWING BENEFITS

Alternative Medicine Benefits — Six self-referred alternative medicine visits per year are covered, with a copayment of $5 per visit. A credit of $60 for Herbal/Homeopathic or Natural Supplies as dispensed in conjunction with an office visit at a Designated Alternative Medicine Center. Providers in CIGNA's Designated Alternative Medicine network must be used when accessing this benefit.

Covered services are:

- Physician evaluation and management
- Physical medicine
- Acupuncture/acupressure
- Homeopathic consultation
- Biofeedback/guided imagery

Pharmacy Benefit — Covered by Walgreens Health Initiative. See *Pharmacy Benefit for CIGNA Medical Plans* section of this booklet for benefit details.

Behavioral Health Benefit — Covered by United Behavioral Health. See *Behavioral Health and Substance Abuse Services* section of this booklet for benefit details.

Vision Benefit — Covered by Avesis. See *Vision* section of this booklet for benefit details.

Please contact the appropriate vendor if you have questions about the pharmacy, behavioral health or vision benefit after reading the specific benefit sections in this booklet.

ADDITIONAL BENEFITS AVAILABLE WITH ALL CIGNA MEDICAL PRODUCTS

- **24-hour, worldwide emergency care**
- **CIGNA *Healthy Rewards* Program** - Discounts on alternative health services and health and wellness products such as Fitness Club Memberships, Chiropractic services, Therapeutic Massage, Acupuncture, Cosmetic Dentistry, Laser Vision Correction, Vitamins and Herbal Supplements, Hearing Aids and Tests. Call 1-800-870-3470 to find out more information or go online to www.cigna.com/healthyrewards.
- **myCigna.com** - Access to your benefit and claim information, request an ID card, view your provider directory, change your PCP, and more through this on line web site
- **Wellness programs** - *Treatment Options* to manage chronic health conditions; *Well Aware Program* for Better Health is an integrated disease management program helping members with asthma, low back pain, cardiovascular disease and diabetes, *Healthy Babies* for prenatal guidance, and more!
- **24-hour Health Information Line** - provides access to health information from Registered Nurses at any time. When you are not sure where to go to seek non-emergency care, you can call and speak to a nurse who can respond to your health care questions; direct you to the nearest participating medical facilities; or provide suggestions for helpful home care that may comfort you until you see your doctor. Call 1-800-564-8982.
- **Working Wonders - Fitness Rewards Program**. Call 1-800-811-1872 to enroll and start earning rewards.
- **Guesting Privileges** - provides access to in-network benefits while you (or your dependent) are temporarily absent from the service area. Call the CIGNA Customer Service Department to determine if you or your dependent qualifies to participate. Certain restrictions apply.

This is a brief summary of your benefits. For more information regarding your CIGNA medical care plan, please contact the CIGNA Customer Service Department, Monday through Friday, 8:00 AM - 5:00 PM MST at 1-800-244-6224 (for HMO or POS) or 1-800-251-0669 (for PPO) or online via email, 24 hours a day. When calling the CIGNA Customer Service Department, please identify yourself as a Maricopa County employee. In addition, you may visit the CIGNA web site to assist in selecting a provider at www.cigna.com. When searching for a provider, from the provider directory link, go to the PCP based plan section and use the AZ Medical Group as the network for the HMO product or AZ central and northern for the POS product. Use the No PCP required section from the provider directory link for the PPO product.. You may also refer to the CIGNA General Service Agreements and provider directories on the Maricopa County Internet web site at http://www.maricopa.gov/benefits/ or via the EBC Intranet at http://ebc.maricopa.gov/hr/benefits.

CIGNA HMO AND POS BENEFITS AT A GLANCE

Revised 11/15/02	HMO Charges/Costs	POS Charges/Costs	
	In-Network	**In-Network**	**Out-of Network**
Standard Benefit Coverage			
Deductible			
Individual	None	None	$300
Family	None	None	$600
Standard Coinsurance Percentage Covered by Plan	100%	100%	70% after deductible
Out of Pocket Maximum for specific services			
Individual	$1,000 OOP Max	$1,000 OOP Max	$3,000 OOP Max
Family	$2,000 OOP Max	$2,000 OOP Max	$6,000 OOP Max
Lifetime Maximum Benefit	Unlimited	Unlimited	$5,000,000
Pre-existing Conditions	None	None	12 Months Waiting Period
General Services			
Preventive Care	$10 Copay	$15 Copay	Covered In-Network Only
Primary Care Physician Services	$10 Copay	$15 Copay	70% after deductible
Specialty Care Physician Services	$10 Copay	$25 Copay	70% after deductible
Urgent Care Facility (Participating)	$35 Copay	$50 Copay	70% after deductible
Out-patient Lab and X-Ray	No Copay for lab or X-Ray $50 Copay for MRI and CAT	No Copay for lab or X-Ray $50 Copay for MRI and CAT	70% after deductible
In-patient Coverage			
Facility Charges	No Copay	$100 Copay (reimbursed by County)	70% after deductible (Precertification Required)
Physician and Surgeon's Services	No Copay	No Copay	70% after deductible (Precertification Required)
Outpatient Surgery	No Copay	$50 Copay	70% after deductible (Precertification Required)
Non-certification Penalty	NA	NA	$400 Penalty
Maternity			
Pre and Postnatal Exams (after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	70% after deductible
Delivery	No Copay	$100 In-Patient Copay (reimbursed by County)	70% after deductible
Emergency Care (Defined by Plan)			
Emergency Room - Copay waived if admitted	$75 Copay	$100 Copay	$100 Copay if emergency, otherwise 70%
Ambulance	No Copay	No Copay	No Copay
Equipment and Devices			
Durable Medical Equipment	No Copay ($3500 Max)	No Copay ($3500 Max)	Covered In-Network Only
External Prosthetics and Orthotics	No Copay ($1000 Max)	No Copay ($1000 Max)	Covered In-Network Only
Outpatient Rehabilitation			
Physical, Speech, and Occupational Therapy	$10 Copay	$10 Copay	70% after deductible
Chiropractic Services Open Access; No referral required; visit limit is per year	$10 Copay 20 visits	$10 Copay 20 Visits	Covered In-Network Only
Maximum Therapy and Chiropractic visits combined per year	60 Visits	60 Visits Combined	
Ancillary Benefits			
Vision and Hearing Screening	$10 Copay	$15 Copay	Covered In-Network Only
Other Healthcare Facilities			
Skilled Nursing Facilities			
Subscriber Payment	No Copay	No Copay	70% after deductible
Limit per Contract Year	90 Days Combined	90 Days Combined	90 Days Combined
Home Health Care	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	70% deductible up to 40 Days/Year
Family Planning			
Sterilization: Vasectomy	Place of Service Copay	Place of Service Copay	70% after deductible
Sterilization: Tubal Ligation	Place of Service Copay	Place of Service Copay	70% after deductible
Infertility Treatment	Diagnostic Services and Corrective Treatment Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only
Dependent Children	Must be unmarried and legally dependent upon employee. Covered to age 19 unless full-time student and then covered to age 25 or if disabled		

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.

CIGNA PPO BENEFITS AT A GLANCE

Revised 11/15/02	PPO Charges/Costs	
	In-Network	**Out-of Network**
Standard Benefit Coverage		
Deductible		
Individual	$250	$750
Family	$500	$1,500
Standard Coinsurance Percentage Covered by Plan	80% after deductible (CIGNA pays 80%, Member pays 20%)	60% after deductible (CIGNA pays 60%, Member pays 40%)
Out of Pocket Maximum for specific services		
Individual	$2,000 OOP Max	$4,000 OOP Max
Family	$6,000 OOP Max	$12,000 OOP Max
Lifetime Maximum Benefit	Unlimited	$5,000,000
Pre-existing Conditions	12 Month Waiting period	12 Month Waiting period
General Services		
Preventive Care	$20 Copay	Covered In-Network Only
Primary Care Physician Services	$20 Copay	60% after deductible
Specialty Care Physician Services	$30 Copay	60% after deductible
Urgent Care Facility (Participating)	$50 Copay	60% after deductible
Out-patient Lab and X-Ray	80% after deductible	60% after deductible
In-patient Coverage		
Facility Charges	80% after deductible	60% after deductible (Precertification Required)
Physician and Surgeon's Services	80% after deductible	60% after deductible (Precertification Required)
Outpatient Surgery	80% after deductible	60% after deductible (Precertification Required)
Non-certification Penalty	$400 Penalty	$400 Penalty
Maternity		
Pre and Postnatal Exams (after pregnancy has been determined)	Copay waived after 1st visit	60% after deductible
Delivery	80% after deductible	60% after deductible
Emergency Care (Defined by Plan)		
Emergency Room - Copay waived if admitted	$100 Copay	$100 Copay if emergency, otherwise 60%
Ambulance	90% after deductible	90% after deductible
Equipment and Devices		
Durable Medical Equipment	80% after deductible ($700 max.)	60% ($700 max.)
External Prosthetics and Orthotics	80% after $200 deductible($1,000 max.)	60% after $200 deductible ($1000 max.)
Outpatient Rehabilitation		
Physical, Speech, and Occupational Therapy; 60 visits per year maximum combined	$20 Copay	60%
Chiropractic Services Open Access; No referral required	$20 Copay Unlimited visits	60% after deductible Unlimited visits
Ancillary Benefits		
Vision and Hearing Screening	$20 Copay	Covered In-Network Only
Other Healthcare Facilities		
Skilled Nursing Facilities		
Subscriber Payment	80% after deductible	60% after deductible
Limit per Contract Year	90 Days Combined	90 Days Combined
Home Health Care	80% after deductible (Unlimited)	60% after deductible up to 40 Days per Year
Family Planning		
Sterilization: Vasectomy	80% after deductible	60% after deductible
Sterilization: Tubal Ligation	80% after deductible	60% after deductible
Infertility Treatment	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only
Dependent Children	Must be unmarried and legally dependent upon employee. Covered to age 19 unless full-time student and then covered to age 25 or if disabled	

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.

PHARMACY BENEFIT FOR CIGNA MEDICAL PLANS

ADMINISTERED BY WALGREENS HEALTH INITIATIVES (WHI)

GROUP NUMBER: See your ID card

All CIGNA medical products have one pharmacy benefit that is administered through WHI. If you select CIGNA HMO, you must fill your prescriptions through a WHI network pharmacy and not through the pharmacies located in the Medical Group (HealthCare) facilities. Regardless of which CIGNA medical plan you chose (HMO, POS, or PPO), you will use the WHI network of pharmacies. Convenient WHI pharmacy locations include Albertson's, Basha's, Fry's, Kmart, Osco, Safeway, Target, Walgreens, CVS, Sam's Club, and Wal-Mart. Many pharmacies have extended hours. Questions about your pharmacy benefit can be answered by calling **WHI's Member Services Department, 24 hours per day, 7 days a week at 1-800-207-2568**.

OBTAINING COVERED PRESCRIPTIONS

With your pharmacy program, you can obtain your prescriptions from three different sources, depending on your needs.

Short-Term Needs - Up to a 30-day Supply at WHI Network Retail Pharmacies

The retail network of pharmacies is available for prescriptions you need right away, for a short time only (such as antibiotics) or on a monthly basis. You can choose from thousands of participating network pharmacies nationwide, and you can obtain up to a 30-day supply at one time. You can find the nearest participating network pharmacy by calling WHI's Member Services at 1-800-207-2568, or by going on-line at www.whphi.com. Coinsurance amounts for this benefit are listed in the next section. A small number of medications are limited to a 30-day or less supply such as but not limited to Accutane or Peg-Intron. These medications may only be purchased at a participating retail pharmacy.

Long-Term Needs - Three Month Supply at Walgreens Retail Stores (Pharmacies)

When you need prescriptions for chronic or long-term health conditions (such as but not limited to high blood pressure, diabetes, or asthma) you can purchase a three-month supply at any pharmacy located in a **Walgreens Retail Store**. The physician must write the prescription for an 84 - 90 day supply otherwise the medication will be filled based on a 30-day retail supply.

Note: Any prescription written for a 31 - 83 day supply will not be filled under your pharmacy benefits. If you choose to fill the prescription any way, the full cost of the medication will be your responsibility.

Long-Term Needs - Three Month Supply through the Mail Service Pharmacy

Prescriptions for maintenance medications or long-term health conditions can also be ordered through the Walgreens Healthcare Plus mail service pharmacy. Ordering through the mail is both a safe and convenient way to receive prescriptions and save money, especially on generics.

You must use a specific order form when placing your first order. This form provides Walgreens Healthcare Plus with important health, allergy, and plan identification information. This form is called **Tempe Registration and Order Form** and is available online at the Benefits Home Page or at WHI's web site: www.whphi.com. You can even register online at the WHI web site instead of completing a hardcopy of the form. **Forms are not available through Walgreens Customer Service.**

Send the completed form, along with your original written prescription to **Walgreens Healthcare Plus, P.O. Box 29061, Phoenix, AZ 85038**. Be sure to include your group number, **on your ID card**, on the form. You may pay by check, money order, VISA, MasterCard, Discover, and American Express. Please do not send your debit card number or cash.

Your doctor may not phone in new prescriptions. However, your doctor may send a new prescription via facsimile (fax). The required form is called the **Tempe Physician Fax Order Form** and is available at www.whphi.com and then selecting the Member Forms link or at the WHI link on the Benefits Home Page.

DRUG UTILIZATION ALERTS AT TIME OF PURCHASE

Drug Utilization Review (DUR) is an effective tool in monitoring drug use to assure that it is appropriate, safe, and effective. WHI's point-of-service DUR program monitors claim submissions across all pharmacies and physicians, compares each claim with the active prescriptions of individual members, and sends "flags" back to the pharmacist should any drug interaction occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) DUR guidelines and monitors every prescription for numerous conditions such as drug interactions, over-utilization, and therapeutic duplication.

SCHEDULE OF PHARMACY COINSURANCE

	GENERIC - TIER 1 **On Formulary**	**BRAND ON - TIER 2 (Preferred)** **On Formulary**	**BRAND OFF - TIER 3 (Non-Preferred)** **NOT On Formulary**
Up to a 30-Day Supply at any Retail Pharmacies in the WHI Network	25% of contract rate minimum $2.00 maximum $10.00	30% of contract rate minimum $5.00 maximum $25.00	30% of contract rate minimum $20.00 maximum $50.00)
Three Month Supply at any Walgreens Retail Stores (Pharmacies)	25% of contract rate minimum $6.00 maximum $30.00	30% of contract rate minimum $15.00 maximum $75.00	30% of contract rate minimum $60.00 maximum $150.00
Three Month Supply through the Walgreens Healthcare Plus Mail Order Facility	20% of contract rate minimum $6.00 maximum $28.00	25% of contract rate minimum $15.00 maximum $70.00	25% of contract rate minimum $60.00 maximum $140.00

FORMULARY

To determine which tier your medication is on, you can review the formulary, which is a listing of most commonly prescribed medications that have received Federal Drug Administration (FDA) approval as safe and effective, and have been chosen for inclusion by a committee of physicians and pharmacists. The formulary lists medications on Tier 1 and Tier 2. Generic, or Tier 1 medications, are shown in lower-case. Brand-name medications are shown in upper case. Brand-name medications that are not listed on the formulary are on Tier 3, unless specifically excluded. A copy of the WHI formulary will be mailed to you with your identification card after you complete the enrollment process. You may also call WHI's Member Service Department for immediate assistance in determining tier level and medication cost. The formulary is also available online at www.whphi.com.

PRIOR AUTHORIZATION

Certain medications require prior authorization (approval) before they will be covered including specific quantity limits within a set timeframe, an age limitation has been reached and/or exceeded, or appropriate utilization must be determined. WHI administers the clinical prior authorization (CPA) process.

Your pharmacist, your physician, or you and/or your dependents may initiate the CPA process by calling 1-877-665-6609, Monday through Friday, 8:00 AM - 8:00 PM, Central. You will need the following information when you request CPA or want to know if a particular medication requires CPA:

- Name of the medication,
- The prescribing physician's name, phone number (and facsimile number, if available),
- Your WHI identification number, and
- Your group number: printed on your ID card.

Categories/medications that require CPA include but are not limited to:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy
- Anabolic steroids (all forms)
- Insomnia
- Proton Pump Inhibitors (PPIs such as Prevacid, Nexium, Protonix, and Aciphex)
- Cox II Inhibitors (i.e., Celebrex, Vioxx, and Bextra)
- Anti-obesity
- Anti-Fungals (i.e., Lamisil, Sporanox, and Diflucan)
- Migraine Medications (all forms of treatment)
- Stadol

If your request for CPA results in a denial, you may file an appeal by completing the appeal form available at the Benefits Office or via the Benefits Home Page.

DIRECT MEMBER REIMBURSEMENT

Your pharmacy benefit is valid only through the WHI network of pharmacies. Should the situation arise where you require medication and must pay for it with your own money, keep your receipt(s). You may request a direct member reimbursement (DMR) by completing the DMR form and submitting it to the Benefits Office. The DMR form is available at the Benefits Office or via the Benefits Home Page. A determination will be made by and communicated to you by the Benefits Office.

The Benefits Office will make a determination and if approved will forward your claims to WHI to process your request for reimbursement according to the Plan's guidelines, coverage, and limitations. If the request is approved, you should receive your reimbursement within four weeks.

Please note that WHI will reimburse you according to the Plan's guidelines. You may receive the contracted amount of the medication, less your coinsurance, instead of the full retail price of the medication less your coinsurance, depending upon the circumstance.

MAXIMUM OUT-OF-POCKET BENEFIT

The coinsurance you pay towards any covered drug will be applied to your maximum out of pocket limit. The maximum out-of-pocket limit is the most that you will pay for covered prescription medications during a calendar year.

- The maximum out-of-pocket for individual coverage is $1,500.
- The maximum out-of-pocket for family coverage is $3,000.

Once you and/or your eligible dependents meet your out-of-pocket maximum, covered prescriptions are paid at 100% by the plan for the remainder of the calendar year. Any number of covered family members can contribute to the family out-of-pocket maximum.

The amount you pay for any *non-covered drug* will not be included in calculating the annual out-of-pocket maximum. You are responsible for paying 100 percent of the cost for any non-covered drug; the contracted rates will not be available to you.

COVERED ITEMS

The following items are covered under the prescription program (unless specifically listed in the *Exclusion and Limitation* section below).

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic medications such as blood glucose monitors, test strips, glucagon, lancets including automatic lancing devices, prescribed oral agents for controlling blood sugar, any of the devices listed above that are needed due to being visually impaired or legally blind, and disposable insulin syringes.

  Note: Insulin cartridges are available through your medical insurance carrier's DME (durable medical equipment) provider.

EXCLUSIONS AND LIMITATIONS

- Drugs used for cosmetic purposes, including but not limited to anti-fungals, hair loss treatments, and those used for pigmenting/depigmenting and reducing wrinkles.
- Fertility drugs (oral and injectible).
- Diabetic urine tests, alcohol swabs.
- Nutritional/Dietary Supplements. **Note**: Medical food products (low protein foods and metabolic formula) to treat inherited metabolic disorders (a disease caused by an inherited abnormality of body chemistry) are covered under your medical plan according to Arizona state statute.
- Over the counter medications and other over the counter items.
- Certain injectibles obtainable through a physician in an office setting. If the medication is available and administered through your physician's office, then it may be covered through your medical plan.
- Miscellaneous medical supplies.
- Prescription drug products for an amount dispensed which exceeds the supply limit (days supply or quantity limit).
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Charges to administer or inject any drug.
- Prescription drugs that are not medically necessary.

- Charges for delivering any drugs, except through the mail order benefit. Express or over night delivery is at the your expense.
- Experimental or investigational medications.
- Prescription drugs purchased from an institutional pharmacy for use while you are an in-patient in that institution regardless of the level-of-care.
- Reimbursement for prescription drugs purchased from a non-participating pharmacy is limited to the contract rate less coinsurance.

This is a brief summary of your pharmacy benefit. For more information regarding your pharmacy benefit, please contact the Walgreens Health Initiative (WHI) Member Service Department, Monday through Friday, 24 hours a day at 1-800-207-2568. Please identify yourself as a Maricopa County employee. A Member Service Representative can assist you in locating participating pharmacies, answering plan design questions, advising what medications are on the formulary, determining your coinsurance to purchase the medication, and alternative medications that you and your physician may want to consider to minimize your out-of-pocket expense.

Walgreens HealthCare Plus' Mail Order Member Service is available by calling 1-888-265-1953, Monday through Friday from 7:00 AM - 7:00 PM and Saturday, 7:00 AM - Noon MST. Mail Order refills may be ordered by calling 1-800-797-3345, Monday through Friday from 7:00 AM - 7:00 PM and Saturday, 7:00 AM - Noon MST.

You may visit the WHI web site at www.whphi.com for many resources and services such as online mail order registration, a pharmacy locator, online ordering of refills, drug formulary, drug information, product news, Mayo Clinic Health Library, Ask a Pharmacist, check drug interactions, view immunization recommendations, and specialty pharmacy for complex health conditions. You may also refer to the Summary Plan Document (SPD) on the Benefits Home Page.

VISION BENEFIT PLAN

ADMINISTERED BY AVESIS

GROUP NUMBER: See your ID card

PLAN NUMBER: also on your ID card

The Avesis vision coverage is provided to you and your eligible dependents who enroll in either the HealthSelect or CIGNA medical plans. If you waive your medical coverage, you are not covered under the Avesis vision plan.

Avesis offers a dual-choice vision benefit. You may choose from a participating network provider (in-network) or non-participating provider (out-of-network). However, when you select a participating network provider, you are assured quality care and maximum savings. If you purchase non-covered options (specialty lenses, additional eyewear, tints, etc.) from a participating network provider, you receive significant savings.

You may choose from one of three in-network options or you may choose to receive your annual vision benefit from an out-of-network provider. If you choose to receive your vision benefit through an out-of-network provider, you must pay the provider and submit an itemized statement for reimbursement of your vision care expenses. You must submit the claim within three months from the date of service. When filing an out-of-network claim, you must provide the following information: employee's identification number, employee's name, mailing address, patient's name, patient's date of birth, and group number: from your ID card.

VISION BENEFITS AT A GLANCE

Benefits	**In-Network Charges/Costs**		**Out-of-Network Charges/Costs**
	Option One (Glasses)	**Option Two (Contact Lenses)**	
Routine Vision Exam	$10 copayment	$10 copayment	Maximum Benefit $35
Single Spectacle Lenses (pair) Includes Polycarbonate, clear glass, or CR39 basic plastic	$10 combined copayment Standard lenses/frames copayment		
Single Vision Lenses			Maximum Benefit $25
Bifocal Lenses			Maximum Benefit $40
Trifocal Lenses			Maximum Benefit $50
Lenticular			Maximum Benefit $80
Frame (within plan allowance)			Maximum Benefit $45
Tints and Coatings	20% of UCR	N/A	Not Covered
Contact Lenses-Elective as determined by Avesis	N/A	$130 allowance applied toward contact lenses and/or professional fitting fees. $10 copayment for exam.	Maximum Benefit: $130 applied toward contact lenses and/or professional fitting fees.
Contact Lenses-Medically Necessary as determined by Avesis		$10 copayment for exam.	Maximum Benefit $250 applied toward exam, contact lenses, and related professional fitting fees.
Option Three (LASIK Surgery Benefit)			
LASIK Surgery	One-time (lifetime) benefit. Takes the place of all other benefits for the benefit year. Through an Avesis Contracted Provider only. $150 allowance applies toward the cost of the LASIK surgery for one or both eyes.		Not Covered

This is a brief summary of your benefits. For more information regarding your vision plan, please contact the Avesis Customer Service Department at 1-800-828-9341, Monday through Friday, 7:00 AM - 5:00 PM MST. When calling the Avesis Customer Service Department, please identify yourself as a Maricopa County employee. In addition, you may visit the Avesis web site for assistance in selecting a provider at www.avesis.com.

You may also refer to the Avesis brochure and provider directory on the Benefits Home Page.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTERED BY UNITED BEHAVIORAL HEALTH (UBH)

Your behavioral health coverage, provided to all Maricopa County employees and their covered dependents who enroll in either HealthSelect or CIGNA medical plans, is just as important as your physical health. When you have physical problems, you go to the doctor. But where do you turn when you have an emotional concern or a personal problem? Or when talking with friends or family is not enough?

Turn to United Behavioral Health (UBH) to support your well being with behavioral health benefits. These services help you deal with a wide range of issues, including:

- Depression
- Severe stress and anxiety
- Alcohol or drug dependency
- Legal concerns
- Eating disorders
- Coping with grief and loss
- Anger management
- Financial worries
- Compulsive gambling
- And more

Through these services you can receive confidential counseling whenever you or your eligible dependents are faced with a personal challenge. Protecting your confidentiality is UBH's top priority. All records, including personal information, referrals, and evaluations, are kept confidential in accordance with federal and state laws.

Provided below is a summary of your benefits. It is important for you to understand that in-network benefits are payable only if each service is determined to be medically necessary and is approved by UBH before you start treatment. Please contact United Behavioral Health at 1- 866-312-3078 for prior authorization. Out-of-network services do not require prior approval, however out-of-network services are limited to outpatient therapy and the benefit is limited to $25 of the provider charges.

UNITED BEHAVIORAL HEALTH BENEFITS AT A GLANCE

	In-Network	Out-of-Network
Deductible	None	None
Inpatient Hospital Care, 30 days per year	$25/day copayment	Not Covered
Intensive Outpatient Program	$100 copayment per program	Not Covered
Outpatient Individual Therapy Visits (in-network and out-of-network visit limit is combined. 30 visits per year)	$10/visit copayment	Benefit pays $25 per visit; you pay the balance of the charges
Outpatient Group therapy visit (in-network and out-of-network visit limit is combined. 60 visits per year)	$5/visit copayment	Benefit pays $25 per visit; you pay the balance of the charges
Residential Treatment, 60 days per year	$12.50/ day copayment	Not covered
Behavioral Health/Substance Abuse Lifetime Maximum	Unlimited	$5,000,000

United Behavioral Health is the leader in behavioral health and wellness services. They design and deliver programs to help people live and work well. For more information regarding your behavioral health plan or to obtain prior authorization or to find participating providers, please contact the UBH Member Service Department at 1-866-312-3078. They are accessible 24 hours per day, 7 days per week. In addition, Member Services can assist you with the many services you will find when you visit the UBH web site www.liveandworkwell.com. This web site contains information and resources to maximize your well being. Find interactive self-improvement programs, download health and wellness articles, participate in online chats with experts, search for community resources, and find out about free legal services and discounts, and free financial consultations with certified financial planners. The access code to this web site, was mailed to your home and is available on the EBC at work.

Note: If you waive your medical coverage, you are not covered for behavioral health and substance abuse services.

In addition to behavioral health and substance abuse services administered by UBH, Sheriff's Office employees, and their dependents, may access the Sheriff's Office Behavioral Health Services Unit (BHSU).

EMPLOYEE ASSISTANCE PLAN

ADMINISTERED BY COMPSYCH GUIDANCE RESOURCES

The Employee Assistance Plan (EAP) is an employer-paid benefit that provides counseling assistance for both personal and work-related issues for you and your dependents regardless if you and/or your dependents are covered under the medical benefit plans. There is no copayment charged to you to use this service. Benefits include one to eight visits individual sessions per person, per problem, per year. Plus, with this benefit, you may use up to six sessions per year during your work time. The behavioral health benefit offered through United Behavioral Health is similar to your EAP benefit. In fact, UBH and ComPsych work together to ensure that you receive the most appropriate care. Since the EAP is offered to you with no copayment, you may want to consider contacting them first to minimize your out-of-pocket costs. ComPsych will refer you to your behavioral health provider, United Behavioral Health, if appropriate.

Note: All employees are eligible for EAP services, even if you waive your medical coverage.

Why is an EAP needed?

Sometimes employees face problems that they cannot solve. Concerns can become overwhelming and affect work performance, personal happiness, family relations, and health. When this occurs, professional help may be needed to resolve the problem before it becomes a larger issue.

What services does ComPsych Guidance Resources provide?

Your EAP provides a full range of counseling and referral services for individual, family and marital concerns; stress and job related matters; child and domestic abuse; and chemical and alcohol dependency assessment. Other services provided are:

- 24-hour crisis intervention;
- Assessment and short-term counseling for personal and work-related problems;
- Referral to professionals and treatment resources throughout Maricopa County for on-going specialized counseling;
- Information and referral to community resources for social service issues (legal concerns, child and elder care, budgeting, self-help groups, etc.).

Who is eligible for EAP services?

All Maricopa County employees, their spouses, and dependent family members may use this service.

How many visits are allowed?

These services provide 1-8 individual counseling sessions for you and your dependents per person, per problem, per year. You may use six of the eight sessions during work hours (with the prior approval/coordination of your supervisor) without using FML or PTO.

Who pays for EAP services?

Maricopa County through their contract with ComPsych Guidance Resources for EAP services, pays for EAP services. There is no charge to you or your dependents for this service.

How is confidentiality protected?

ComPsych Guidance Resources provides the strictest confidentiality possible, as set forth in State and Federal statutes. Your employer, co-workers, or family members will have no knowledge of your discussion with counselors. If sufficient need is shown, your counselor may encourage other members of your family to participate upon your approval. Release of information by the EAP concerning an individual can only be given with your written consent, except where required by law (i.e., suspected of child abuse or posing a danger to self or others).

To make an appointment, call ComPsych Guidance Resources at 1-888-355-5385 - 24 hours a day, 7 days a week. You can expect to obtain an appointment within 5-7 business days. You can also access legal, financial advisement and information on mental health topics at the ComPsych web site at www.guidanceresources.com. The Maricopa County identification code was mailed to your home and is available on the EBC at work.

In addition to EAP services administered by ComPsych Guidance Resources, Sheriff's Office employees, and their dependents, may access the Sheriff's Office Behavioral Health Services Unit (BHSU).

DENTAL PLANS

Maricopa County employees may purchase dental insurance from one of two dental vendors, United Concordia or Employers Dental Service (EDS). Dental coverage may be purchased even if you waive medical insurance coverage.

ADMINISTERED BY UNITED CONCORDIA DENTAL

GROUP NUMBER: See your ID card

United Concordia Dental offers you freedom of choice in selecting your dental provider by offering a product with in-network benefits as well as out-of-network benefits.

If your dentist participates in United Concordia's network, the dentist will submit your claim, receive direct payment from United Concordia, and accept the fee paid as payment in full (after your deductible and/or copayment).

If you use a non-participating, out-of-network dentist, you can assign payments to that dentist by signing the claim form appropriately. If you do this, your dentist will likely submit the claim for you since the dentist will be paid directly by United Concordia Dental. If the dentist will not bill United Concordia directly, you will be responsible for submitting the claim.

United Concordia compensates all dentists according to its maximum allowable charge (MAC) schedules. Participating dentists agree to accept these allowances as payment in full, for covered services less applicable copayments, coinsurance and deductibles. Non-participating providers are under no obligation to accept the payment as full payment, and may bill you for the difference between the billed charges and United Concordia's MAC schedule.

A pre-determination of benefits is not required to access services, but it is recommended before you begin treatment for complex procedures, such as crowns, bridges, dentures or non-acute periodontal surgery. If you use out-of-network dentists, you should consider a pre-determination of benefits before beginning any treatment. That way, you will know whether the service is covered and exactly what your financial responsibility will be before incurring the charges.

Claim forms, the summary of benefits, the plan document, and provider directory are available through the Benefits Home page by clicking on the link for United Concordia Dental. Assistance is also available by calling United Concordia's Customer Service Department at 1-800-332-0366 Monday through Friday, 8:00 AM - 5:00 PM PST or through its web site at www.ucci.com. A chart comparing United Concordia's benefits to the benefits offered by the other dental plan is displayed following the description of the EDS services. Please refer to the full summary of benefits and plan document, available through the Benefits Home Page, for more specific information regarding plan limitations and exclusions before using services.

ADMINISTERED BY EMPLOYERS DENTAL SERVICES (EDS)

GROUP NUMBER: See your ID card

Employer's Dental Service (EDS) is a prepaid dental care organization. The advantages of joining a prepaid dental plan include no deductible, no claim forms, no yearly maximums, orthodontic services for children and adults, a prescription discount program, a large network of participating dentists, emergency benefit 24 hours a day, value and affordability with a focus on preventive procedures.

Specialty care is provided at a discount. A discount for the treatment of TMJ is also part of your dental care benefit. A referral is not required to see an EDS Specialist.

Immediate coverage is available for basic, preventive and major services. EDS covers pre-existing conditions, except for procedures in progress. As an EDS member, you choose a General dentist from the network of contracted (participating) dentists. All members of your family choose the same dentist. You have the freedom to change dentists, with all changes received by the 20th of the month becoming effective the first of the following month.

A brief summary of benefits is shown below. The coverage booklet and links to the EDS web site are available through the Benefits Home Page by clicking on the link for EDS Dental. The Provider Search database on the EDS web site at www.mydentalplan.net is updated every two weeks. The most recent dentist directory is located under the Member Forms menu.

EDS Customer Service is also available to answer your questions by calling 602-248-8912, Monday through Friday, 8:00 AM - 5:00 PM MST. Customer Service can help you select a dentist, change your current dentist, explain benefits and your costs, process a new ID card, resolve and report a concern, explain the grievance process, and facilitate care for a dental emergency.

Please refer to the full coverage booklet for more specific information regarding plan limitations and exclusions before using services.

DENTAL PLANS COMPARED

Features	United Concordia	Employers Dental Services
Annual Calendar Year Maximum per person	$2,000	None
Orthodontic Service	Diagnostic, active and retention treatment 50% coinsurance Adults and dependent students through age 24 $1,500 Lifetime Orthodontic Maximum; lifetime maximum will be coordinated with prior group insurance carrier; continuing services previously covered under a pre-paid dental plan will not be covered.	Up to two years active banding: Under age 19 copayment of $2,475 - $3,345 copayment Over age 19 copayment of $2,675 - $3,595 copayment Not all procedures or treatments are covered; some limitations and exclusions apply
Provider Network Access	In-Network (participating) and Out-of-Network, (non-participating) providers both available	Must use EDS contracted dentists
Deductible	$50 per person/$100 per family (waived for diagnostic, preventive and orthodontic services)	None
Diagnostic and Preventive Services	100% coverage for Diagnostic, Preventive, and Palliative Services Routine Oral Exams/ cleanings (twice/year) X-rays (limits apply) Sealants of permanent molars (through age 15) Fluoride (twice per year through age 18)	Diagnostic and Preventive Services(at general dentist): Office visit/$3 Routine Oral Exam - $0 Cleaning - $0 Oral exam - $0 X-rays - $0 Sealants -$12 per tooth Fluoride - $0 Emergency Services - up to $200 reimbursement less applicable copayment(s)
Basic Restoration Services	Basic Services 80% coverage Fillings (amalgam on posterior teeth) Oral Surgery Endodontics Periodontics Repair of denture and bridgework Simple extractions Complex Oral Surgery General Anesthesia	Basic Services (at general dentist): Fillings (amalgam) $8 - $21 copayment Fillings (resin) $22 - $40 copayment Oral Surgery: from $35 copayment Endodontics: root canal $170 - $265 copayment Periodontics: debridement $80 copayment; Scaling and root planing/quadrant $90 copayment
Major Services	Major Restorative 50% coverage Inlays, Onlays, Crowns Partial or complete dentures Fixed bridges	Major Restorative(at general dentist): Crown porcelain w/metal $250 copayment + lab fee Complete dentures upper or lower $325 copayment for each + lab fee Partial dentures upper or lower (resin base) $375 copayment for each + lab fee Bridge per pontic $250 copayment + lab fee

LIFE INSURANCE PLAN

ADMINISTERED BY UNUMPROVIDENT CORPORATION

Your basic life, supplemental life, and accidental death and dismemberment insurance is provided through UnumProvident. Medical underwriting may be required. See the rates found in the *2003 Premium Rates* section.

BASIC TERM LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

The County provides you with and pays for a basic term life insurance benefit equal to your Salary, up to $500,000 per year, (excluding overtime, bonus, or commissions) rounded to the next highest $1,000. Coverage begins the first pay period following 14 days after your completed enrollment form is submitted to the Benefits Office.

SUPPLEMENTAL TERM LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

If you wish additional protection, you can purchase supplemental term life and/or AD&D insurance. You can elect coverage in amounts of one to five times your annual salary upon your initial hire. Coverage is rounded to the next highest $1,000. - If you elect more than $500,000 of life coverage, you will be required to provide evidence of insurability (proof of good health). Otherwise, evidence of insurability is not required initially. The maximum insurance coverage you can purchase is $1,000,000 (Basic and Supplemental combined).

Life benefits are paid for any cause of death. Accidental Death and Dismemberment benefits are paid in addition to the death benefit if an accident is the cause of death.

If you don't enroll in supplemental life and AD&D insurance when you complete and submit your initial enrollment form, you can increase your coverage from one to five times your salary within 31 days of a change in status (as defined in the regulations under IRC section 125) without completing an evidence of insurability form, unless the requested amount is over $500,000.

You may also choose to purchase or increase your supplemental life and AD&D coverage by one level during open enrollment. Increasing coverage by more than one level requires that you complete an evidence of insurability form, available at the Benefits Office or on the Benefits Home Page. Coverage is not effective until Unum's Underwriting Department approves your application.

Alternatively, you can request additional coverage at any time by completing the evidence of insurability form. Coverage is not effective until underwriting approves your application.

Unum will review the information on the evidence of insurability form and make a determination whether to approve or deny your request for additional coverage. Unum may request additional information, including, but not limited to, medical records, when making their determination. Coverage does not become effective until Unum approves your request. The effective date of coverage is the date of the approval and is not retroactive to the date of completion of the form. If you are not approved for the increase in your coverage, you will stay at the same coverage level you had before completing the form.

TERMINAL ILLNESS BENEFIT

If you or your covered dependent are diagnosed with a terminal illness and your life expectancy is less than 12 months, you may apply for the accelerated death benefit, 50 percent of your supplemental life insurance benefit up to $500,000, whichever is less.

SPECIAL RATES FOR NON-SMOKERS

As part of the County's commitment to good health, a reward is offered for leading a healthier lifestyle. If you are a non-smoker, your life insurance premiums are lower than the rate for an employee who smokes.

Note: The contract has an incontestability clause, which states that any statements that are made by an employee and found to be untrue or incomplete at the time they are made can result in a reduction or denial of any claim made during the first two years of coverage.

DEPENDENT LIFE COVERAGE

In addition to life insurance for yourself, you can choose two levels of life insurance for your eligible dependents.

Note: You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

When you or your spouse reach age 70, life insurance will be reduced to 65 percent of the original amount, and at age 75, life insurance will be reduced to 50 percent of the original amount.

BASIC AND SUPPLEMENTAL LIFE INSURANCE PORTABILITY

If your employment ends, you retire from Maricopa County, or you become ineligible for benefits, you may elect portable coverage for yourself and your dependents. The portable insurance coverage will be your current coverage and amounts that you and your dependents are insured for but not more than $750,000. The cost of the coverage will differ from the current amount you are paying. You must forward the completed portability application, available at the Benefits Office or on the Benefits Home Page, in addition to the first month's premium, to Unum within 45 days of the time you lose your eligibility for benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT CONVERSION

If your employment ends, you retire from Maricopa County, or you become ineligible for benefits and you are under age 70, you can convert your AD&D coverage to a maximum of $250,000. To apply for conversion, you must request a conversion application form, available from UnumProvident Customer Service at 1-800-421-0344, Monday through Friday, 8:00 AM - 8:00 PM EST, which includes cost information. Upon completion of the application, it must be sent to Unum with the first month's premium within 45 days from your termination date.

The evidence of insurability form, insurance certificate and other forms and information are available through the Benefits Home Page by clicking on the link for Life Insurance. Assistance is also available by calling UnumProvident Customer Service at 1-800-421-0344, Monday through Friday, 8:00 AM - 8:00 PM EST, or through its web site at www.unum.com. Please refer to your life insurance certificate for more specific information regarding plan limitations and exclusions.

BENEFICIARY

You should name a beneficiary for your death benefits at the time you become insured. You may name more than one beneficiary and designate each as primary and/or contingent (secondary). You may assign a percentage to each designation. You may change your beneficiary at any time. The new beneficiary designation will be effective as of the date you sign a change form or file an electronic designation in the open enrollment system.

SHORT-TERM DISABILITY BENEFITS

ADMINISTERED BY UNUMPROVIDENT CORPORATION

UnumProvident provides your short-term disability (STD) insurance. The STD plan pays benefits if you are unable to work and lose income because of a covered illness or injury for which you are being treated. Benefit highlights are listed below.

The Short-Term Disability Booklet is available on the Benefits Home Page by clicking on the link for Disability. Assistance is also available by calling Disability Management at 602-506-6182 Monday through Friday, 8:00 AM - 5:00 PM MST. Please refer to the full STD booklet for more specific information regarding plan coverage information, limitations and exclusions before using services.

You can choose one of the following benefit levels, subject to a $1,000 maximum weekly benefit.

- 50% of regular weekly salary
- 60% of regular weekly salary
- 70% of regular weekly salary

You may increase your coverage only during a regularly scheduled open enrollment period. Coverage can be decreased or cancelled at any time.

Benefits may continue up to a maximum of 26 weeks, including the elimination or benefit waiting period and any partial disability payment periods or intermittent periods of work where you do not return to work for more than two consecutive weeks at 100 percent of the job's regular hours.

If you go on an unpaid leave of absence, you must continue to pay the insurance premium (your portion of the premium for FML leave of absence or the full premium for non-FML leave of absence) in order to continue coverage Refer to *Do Benefits Continue While on a Leave of Absence s*ection. Non-payment of premium will result in coverage cancellation effective the last day of the pay period in which premium was paid. It is your responsibility to contact the Benefits Office to make premium payment arrangements.

There is a 14 consecutive day benefit waiting period from onset of disability until your benefit becomes payable. Benefits are paid weekly for up to a maximum of 26 weeks from the date of disability (including your waiting period and any accruals used) or until your disability ends, whichever comes first.

The STD benefit includes a return-to-work incentive that is designed to lessen the financial hardship that your disability caused. You may not be able to return full-time, however, if you return part-time, your STD benefit will continue to support your recovery by continuing to pay your benefit within certain limits in addition to your part-time earnings.

You can earn up to 30 percent of your pre-disability earnings and not have your STD benefit affected. If you earn more than 30 percent of your pre-disability earnings in your regular occupation or another occupation, then your STD benefit will pay you up to 100 percent of your pre-disability gross (base) earnings when you add your part-time earnings to your weekly benefit. If your weekly benefit and your earnings exceed 100 percent of your pre-disability earning, then your benefit will be reduced so that the total amount equals 100 percent of your pre-disability wage.

The return-to-work incentive begins the first day you perform part-time work earning beyond 30 percent of your pre-disability income. It will continue for a period of up to 13 weeks elapsed time, or until you stop working part-time and are totally disabled, or until you are no longer disabled whichever occurs first. Refer to the STD Summary Plan Description for specific details.

Your benefit will be reduced by any income that you receive, including but not limited to:

- County-provided PTO/FML (sick leave pay for courts)*
- County paid donated leave
- Any Workers' Compensation payments including income protection
- All retirement or disability benefits from any State or Government plan
- Any benefits or payments you are eligible to receive for disability, or loss of time or income, to which the employer, trade, or professional organization directly or indirectly sponsored or contributed.
- All Veteran's disability pension benefits if received for the same disability
- No Fault Insurance award or Third Party Subrogation

*You are required to use all FML before beginning STD. PTO can be saved and not used after accruals have been used for the first 14- day waiting period. Please discuss with your Disability Manager.

If you are disabled, return to work, and become disabled again due to the same or related cause, the second disability will be considered a continuation of the first period of disability, as long as you returned to work for less than 14 consecutive calendar days. If the second disability is unrelated to the first, or if you returned to work for more than 14 days, the second period of disability will be considered a separate claim and a new waiting period must be satisfied before benefits become payable.

PRE-EXISTING CONDITION LIMITATION FOR STD

If you have a disability for which you received treatment (including diagnostic services and/or prescription drugs) within 90 days before your coverage became effective, no benefits will be payable for that condition until you have been treatment-free for three months or covered by the plan for twelve months. The pre-existing condition also applies to the difference between the current and increased benefit level changes made during open enrollment.

MARIFLEX FLEXIBLE SPENDING ACCOUNTS

Mariflex Flexible Spending Accounts (FSA) mean more money in your pocket!

By participating in this benefit, you can save Federal, State, Medicare, and FICA taxes on money contributed to an FSA to cover the costs of:

- Health Care Expenses (Medical, Dental, Vision)
- Dependent Care Expenses (Child care, Adult care)

All contributions must be used for expenses incurred from your effective date of eligibility through the end date of coverage during the Plan Year. Please refer to the *When Does Coverage Begin?* And *When Does Coverage End?* sections for more details. The Plan Year begins January 1 and ends December 31. If you do not use all of your contributions, the remaining balance will not be refunded to you or carried forward to the next Plan Year. All claims must be filed no later than March 31 of the following year.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

A health care FSA is an account to which you contribute pre-tax money to pay for health care expenses that are not covered by your insurance coverage. Allowable health care expenses are defined in Section 213 of the Internal Revenue Code and include expenses that are not paid by any insurance, except insurance premiums, long-term care expenses and expenses incurred for strictly cosmetic procedures. Refer to IRS Publication 502 for additional information. Health Care expenses that can be reimbursed on a pre-tax basis through a health care FSA include, but are not limited to:

- Eye exams, contact lenses, contact lens solution, glasses, LASIK surgery;
- Dental exams, cleaning, fillings, crowns, braces;
- Chiropractic care;
- Prescription drugs and insulin;
- Hearing aids and exams;
- Mileage to and from a medical appointment;
- Treatment for obesity (including Weight Watchers meeting fees), and
- Copayments, coinsurance, and deductibles.

You can include expenses for everyone on your Federal tax return, even if you do not cover them on your County medical or dental insurance.

You may elect to contribute up to $5,200 per year into a health care spending account.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A dependent care FSA is an account to which you contribute pre-tax money to pay for dependent care expenses. Dependent Care expenses include child and/or adult dependent care expenses you incur that enable you to work. If you are married, your spouse must also work or be a full-time student. You must claim the dependent on your tax return. If you are divorced, you must be the custodial parent, but you are not required to claim the tax exemption. Your child must be under 13 or if care is for an older person, he/she must be incapable of self-care. Refer to IRS publication 503 for more information. Expenses include, but are not limited to, such things as:

- Day care centers (must comply with state and local laws),
- Babysitters,
- Pre-school (before Kindergarten), and
- General-purpose day camps.
- Educational expenses, including tuition for Kindergarten, are not eligible expenses.

You may elect to contribute up to $5000 per year into a dependent care spending account.

SPENDING ACCOUNT OVERVIEW

You decide how much to set aside in one or both accounts for the Plan Year, up to the maximums. This is called your "election." Your election amount will be divided by the number of paychecks you will receive during the Plan (calendar) year. A full Plan Year has 26 pay periods. If you are a new hire, the Plan Year begins on your benefit effective date and the number of pay periods will be less than 26 and will be calculated on your benefit effective date. Your gross compensation will be reduced by this pre-taxed amount each paycheck to fund the FSA. After you incur a qualifying expense during the time you were enrolled in the FSA, you file a claim with the Mariflex Administrator. Claims are processed, and reimbursements are issued on a daily basis. Direct deposit of claims payments into your checking or savings account is available.

An expense is considered incurred when the services are provided or the products are ordered. Expenses must be incurred between your effective date of coverage and the end of the Plan Year. Your coverage period will be shorter should you leave County service and do not continue to pay your elected amount.

When calculating your elected amount, include only those expenses that you are sure you will incur since any amount you do not use for qualifying expenses cannot be returned to you. As you plan, ask yourself these questions before you enroll in the health care spending account:

- Will I have medical/dental expenses that are not covered by my health plan?
- How much were these expenses last year?
- Will these expenses be the same this year? More? Less?
- Will I experience a change in status event this year that will allow me to change my contributions later in the year?

Claim forms, the plan summary, direct deposit form, and a link to the home page of the Mariflex Administrator are available through the Benefits Home Page by clicking on the link for Mariflex. Assistance is also available by calling ASI Customer Service at 1-800-659-3035, Monday through Friday, 7:00 AM - 7:00 PM CST, through the web site at www.asiflex.com, or by email at asi@asiflex.com. Please refer to the full plan summary and the IRS publications for more specific information regarding plan limitations and exclusions before enrolling.

TAX SAVINGS

When you elect to participate in the health and/or dependent care FSA, under IRS rules, you are asking Maricopa County to reduce your taxable income in exchange for a before-tax benefit. Thus, your contributions reduce what is reported as income on your W-2 Form. Your contributions are not subject to Medicare, FICA, and federal and state income taxes. The result is that you pay no tax on the amount you contribute. The net effect to you is a lower cost health care and/or dependent care expense.

EXAMPLE OF MARIFLEX SAVINGS

Annual Mariflex Contribution		Amount Deducted from Each Pay Check
*$3,000	divided by 26 pay periods =	$115.38
**$5,000	divided by 26 pay periods =	$192.31

	No Mariflex	$3,000 Annual Mariflex*	$5,000 Annual Mariflex**
Gross Pay	$1,346.40	$1,346.40	$1,346.40
ASRS	$26.93	$26.93	$26.93
ASRS LTD	$6.60	$6.60	$6.60
CIGNA (pre-taxed)	$47.02	$47.02	$47.02
Dental (pre-taxed)	$17.88	$17.88	$17.88
Mariflex	$0	*$115.38	**$192.31
FICA	$79.45	$72.30	$67.53
Medicare	$18.58	$16.91	$15.79
Fed Tax	$93.28	$75.97	$64.44
State Tax	$27.05	$22.03	$18.69
Net Pay	$1,029.61	$945.38	$889.21
Mariflex Reimbursement	$0	$115.38	$192.31
Actual Net Pay	**$1,029.61**	**$1,060.76**	**$1,081.52**
Savings per Pay Period	**$0**	**+$31.15**	**++$51.91**
Annual Savings	**$0**	**$809.90**	**$1,349.66**

+$3,000 Annual Mariflex - No Mariflex = $31.15 ++$5,000 Annual Mariflex - No Mariflex = $51.91

Annual Savings = Savings per Pay Period x 26 weeks

Above scenarios based on $35,000 annual income; Federal Tax withholding at Married with 2 dependents, State tax withholding at 20%; Participates in ASRS. ASRS rates used are effective July 1, 2002. Your estimated savings will depend on your income tax filing status, and tax bracket.

ADDITIONAL BENEFITS

A brief summary of additional benefits is provided below. For detailed information, please access the Benefits Home page on the EBC Intranet at ebc.maricopa.gov/hr/benefits or the Internet at www.maricopa.gov/benefits.

AUTO, HOME, AND RENTERS INSURANCE

Administered by Liberty Mutual

As a Maricopa County Employee, you qualify for a special group discount* on your auto, home, and renters insurance through Group Savings Plus® from Liberty Mutual. With Group Savings Plus, you can enjoy the ease and convenience of paying your premiums through payroll deduction or checking account deductions with no down payment or finance charges. You'll also enjoy fast, easy round-the-clock claims service and a variety of discounts including multi-car, multi-policy, safe-driver, passive restraints and anti-theft device discounts.*

See for yourself how much money you could save with Liberty Mutual compared to your current insurance provider. For a free, no-obligation quote, call 1-800-221-8135, or request a free quote on-line!

To learn more about Liberty Mutual, visit their web site at www.libertymutual.com/lm/maricopafcu.

* Group discounts, other discounts, and credits are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverage only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage is provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.

CRITICAL ILLNESS COVERAGE

ADMINISTERED BY TRUSTMARK

Premier Protector Critical Illness Insurance

Protecting the lifestyle and financial security of our employees is a primary consideration in decisions made by Maricopa County. We also recognize that each employee's family situation and insurance needs are different.

It is with these goals in mind that we are able to respond by providing an exciting supplemental critical illness insurance plan, underwritten by Trustmark Insurance Company. This benefit program is available to you and your dependents on a very competitive group basis through the convenience of payroll deduction.

Trustmark's Premier Protector Critical Illness Insurance pays a lump-sum amount upon the initial diagnosis of any covered critical illness. The plan is designed to cover indirect expenses associated with a critical illness such as; loss of income, deductibles and copayments/coinsurance, alternative treatments, meals and lodging, out-of-network treatments, home recovery, family care, and living expenses.

Trustmark's Premier Protector Critical Illness Insurance complements existing benefits and enables you to customize your insurance package to meet your specific needs. This program is appropriate for single as well as married individuals and, unlike traditional group insurance; this plan may be continued upon termination of employment at no increased cost.

For additional information or to sign-up, please contact Einstein Benefit Communications at:

- Enrollment Services: (480) 991-4444, ext. 15
- Enrollment Fax: (480) 596-9833
- E-mail: enrollment@einsteinbenefit.com

DEFERRED COMPENSATION

ADMINISTERED BY NATIONWIDE RETIREMENT SOLUTIONS

Maricopa County, in partnership with **Nationwide Retirement Solutions** (formally known as PEBSCO), offers you one of the best Deferred Compensation plans in the country.

What are the benefits of a deferred compensation program?

It's tax deferred. A deferred compensation program lets you contribute money to your account first-before it's taxed-and postpone paying income taxes until retirement. By postponing current income taxes on your contributions, you have more money to grow and compound over the years. This plan is tied to employment, not age. This means that you are eligible to take out the funds when you separate service from Maricopa County regardless of your age.

How much may I contribute from my paycheck?

The minimum contribution amount is $20 per month. The maximum contribution amount is $12,000 per year if under age 50, $14,000 per year if over age 50, and $24,000 per year if 3 years before retirement and have past dollars to "catch-up." A Nationwide Retirement Solutions Specialist can assist you in answering your specific questions.

How much should I contribute?

There is no "one-size-fits-all" answer to this question, but the general answer is "as much as you can". A more accurate answer depends on many variables, including the amounts you might receive from your pension when you retire and Social Security, what your investments earn between now and the time you retire, and what kind of standard of living you want at retirement. Regardless of how much you can afford to contribute, there are big benefits to joining the Deferred Compensation program sooner rather than later.

Why should I start now?

There are two important factors that can help your retirement account grow: time value of money and compounding interest. The sooner you start, the better. Why not start today!

How do I know where to invest my money?

Licensed and trained Retirement Specialists can provide personalized assistance with your retirement needs at a face-to-face meeting. Retirement Specialists are also available to you through a unique service called Direct Access. Nationwide Retirement Solutions has teamed with Ibbotson Associates, one of the nation's premier providers on investment modeling, and are introducing a new program based on an Ibbotson asset allocation model, a tool designed to help you decide just what type of an investor you are.

From what type of investment options do I have to pick?

Nationwide Retirement Solutions offers a wide range of investment options, which serves every investor's needs. Nationwide also offers a Personal Choice Retirement Account (PCRA), in conjunction with Charles Schwab, that allows you to invest in stocks, mutual funds and a variety of other securities not offered through the core program. Our core program offers funds, including fund families such as Vanguard, American Century, Putnam, Janus, Fidelity, and INVESCO.

I want to enroll. Whom do I contact?

Nationwide Retirement Solutions, Local office telephone: 602-266-2733

To request a face-to-face visit with a retirement specialist

- Toll free customer service: 1-800-598-4457
- Web site address: www.maricopadc.com
- Walk in service: 4747 N. 7th St., #418, Phoenix, AZ 85014

2003 PREMIUM RATES

Important Reminder: Payroll deductions for the insurance plans will be made each payday, 26 paydays per Calendar Year. Premiums listed reflect the biweekly payroll deduction. Actual premium deduction may vary by 1 or 2 cents due to rounding.

HEALTHSELECT

Premium includes coverage for Medical, Pharmacy, Behavioral Health and Substance Abuse, and Vision. Medical and pharmacy coverage is provided by HealthSelect. Behavioral health and substance abuse coverage is provided by United Behavioral Health. Vision coverage is provided by Avesis.

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 - 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$114.81	***$0.00***	$114.81	***$0.00***
Employee and Spouse	$204.53	***$14.62***	$204.53	***$14.62***
Employee and Child(ren)	$171.60	***$11.22***	$171.60	***$11.22***
Employee and Family	$256.60	***$33.38***	$256.60	***$33.38***

CIGNA HMO

Premium includes coverage for Medical, Pharmacy, Behavioral Health and Substance Abuse, and Vision. The medical coverage is provided by CIGNA. The pharmacy coverage is administered by Walgreens Health Initiatives (WHI). The behavioral health and substance abuse coverage is provided by United Behavioral Health. The vision coverage is provided by Avesis.

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 - 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$128.33	***$2.74***	$84.04	***$47.02***
Employee and Spouse	$233.05	***$27.20***	$188.74	***$71.48***
Employee and Child(ren)	$197.02	***$18.82***	$152.73	***$63.11***
Employee and Family	$302.05	***$43.38***	$257.76	***$87.67***

CIGNA PRIME OPTION POS

Premium includes coverage for Medical, Pharmacy, Behavioral Health and Substance Abuse, and Vision. Medical coverage is provided by CIGNA. Pharmacy coverage is administered by Walgreens Health Initiatives (WHI). Behavioral health and substance abuse coverage is provided by United Behavioral Health. Vision coverage is provided by Avesis.

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 - 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$128.33	***$9.52***	$84.04	***$53.81***
Employee and Spouse	$233.05	***$40.80***	$188.74	***$85.08***
Employee and Child(ren)	$197.02	***$30.04***	$152.73	***$74.32***
Employee and Family	$302.05	***$61.41***	$257.76	***$105.70***

CIGNA PPO (PREFERRED PROVIDER ORGANIZATION)

Premium includes coverage for Medical, Pharmacy, Behavioral Health and Substance Abuse, and Vision. Medical coverage is provided by CIGNA. Pharmacy coverage is administered by Walgreens Health Initiatives (WHI). Behavioral health and substance abuse coverage is provided by United Behavioral Health. Vision coverage is provided by Avesis.

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 - 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$126.52	***$38.29***	$82.24	***$82.57***
Employee and Spouse	$231.22	***$98.30***	$186.94	***$142.58***
Employee and Child(ren)	$195.22	***$77.48***	$150.93	***$121.77***
Employee and Family	$300.24	***$137.59***	$255.96	***$181.87***

DENTAL PLANS

Employee Choices:	**Employer Dental Services (EDS)**		**United Concordia**	
	Pre-Paid Dental		***PPO Dental***	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$2.18	***$1.65***	$7.65	***$5.77***
Employee and Spouse	$4.17	***$3.15***	$16.87	***$12.73***
Employee and Child(ren)	$5.42	***$4.09***	$18.24	***$13.76***
Employee and Family	$6.30	***$4.75***	$23.45	***$17.69***

BASIC LIFE INSURANCE

BASIC LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1 Times Salary (Paid by Maricopa County)

SUPPLEMENTAL LIFE INSURANCE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1 to 5 Times Salary (Paid by Employee)

SUPPLEMENTAL LIFE INSURANCE TABLE

5 Year Age Categories	**Employee Cost per Payday Per $1,000 of Coverage**	**Employee Cost per Payday Per $1,000 of Coverage**
	Smoker Multiplier	***Non-Smoker Multiplier***
15-24	$0.043538	$0.031338
25-29	$0.046538	$0.035038
30-34	$0.049538	$0.042538
35-39	$0.078538	$0.046538
40-44	$0.107538	$0.057538
45-49	$0.202538	$0.093538
50-54	$0.363538	$0.162538
55-59	$0.370538	$0.206538
60-64	$0.565538	$0.343538
65-69	$0.689538	$0.482538
70 and older	$1.123538	$0.883538

SUPPLEMENTAL LIFE INSURANCE EXAMPLE

1. Take your annual salary - **Example: $24,500**					
2. Round **up** to the nearest $1,000 and then multiply	1 X Salary	2 X Salary	3 X Salary	4 X Salary	5 X Salary
	$25,000	$50,000	$75,000	$100,000	$125,000
3. Take the Salary amount and divide by $1,000	25	50	75	100	125
4. Refer to the Supplemental Life Insurance table above to find your age category and cost multiplier					
5. Multiply the results from the calculation in Step 3 by the multiplier.					

Example: Age 37	***Multiplier for Smoking***	***Multiplier for Non-Smoking***	***Coverage Amount***
	0.078538	***0.046538***	
1 X Salary	0.078538 X 25 = $1.96	0.046538 X 25 = $1.16	$25,000
2 X Salary	0.078538 X 50 = $3.93	0.046538 X 50 = $2.33	$50,000
3 X Salary	0.078538 X 75 = $5.89	0.046538 X 75 = $3.49	$75,000
4 X Salary	0.078538 X 100 = $7.85	0.046538 X 100 = $4.65	$100,000
5 X Salary	0.078538 X 125 = $9.82	0.046538 X 125 = $5.82	$125,000

DEPENDENT LIFE INSURANCE

100 percent Paid by Employee

	Option One	**Option Two**
Spouse	$5,000	$10,000
Children, live birth to 14 days	$1,000	$1,000
14 days to 19 years, 25 years if full-time student	$2,500	$5,000
Employee Cost Per Payday:	***$0.77***	***$1.54***

SHORT-TERM DISABILITY PLAN

100 percent Paid by Employee

Multiply Your Biweekly Base Pay by the Following Rate:	**Biweekly Rate Multiple of Pay**
50% of Biweekly Base Salary ($2,000 bi-weekly maximum benefit)	$0.0050
60% of Biweekly Base Salary ($2,000 bi-weekly maximum benefit)	$0.0060
70% of Biweekly Base Salary ($2,000 bi-weekly maximum benefit)	$0.0070

SHORT-TERM DISABILITY EXAMPLE

Annual Salary: **$25,000**	**50% Premium**	**60% Premium**	**70% Premium**
Multiply Annual Salary by the multiplier to determine annual premium	$25,000 X 0.005	$25,000 X 0.006	$25,000 X 0.007
Annual Premium	**$125**	**$150**	**$175**
Divide Annual Premium by 26 (represents 26 pay periods) to determine payroll deduction	$125 ÷ 26	$150 ÷ 26	$175 ÷ 26
Payroll Deduction	**$4.81**	**$5.77**	**$6.73**

You must have a qualified status change as defined by the Internal Revenue Code under the Section 125 in order to change your medical, dental, or reimbursement accounts after initial enrollment or following the closing date of the Open Enrollment period for 2003. Please refer *to When Can Changes be Made?* and *What is a Qualified Status Change?* sections.

The information and benefits described in this booklet are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern. All references to year refer to a calendar year.

2003 PAYROLL SCHEDULE

Pay Period	*Mariflex*[Ä]	*Beginning*	*Ending*	*Payday*
1	26	December 23, 2002	January 5, 2003	January 10, 2003
2	25	January 6, 2003	January 19, 2003	January 24, 2003
3	24	January 20, 2003	February 2, 2003	February 7, 2003
4	23	February 3, 2003	February 16, 2003	February 21, 2003
5	22	February 17, 2003	March 2, 2003	March 7, 2003
6	21	March 3, 2003	March 16, 2003	March 21, 2003
7	20	March 17, 2003	March 30, 2003	April 4, 2003
8	19	March 31, 2003	April 13, 2003	April 18, 2003
9	18	April 14, 2003	April 27, 2003	May 2, 2003
10	17	April 28, 2003	May 11, 2003	May 16, 2003
11	16	May 12, 2003	May 25, 2003	May 30, 2003
12	15	May 26, 2003	June 8, 2003	June 13, 2003
13	14	June 9, 2003	June 22, 2003	June 27 , 2003
14	13	June 23, 2003	July 6, 2003	July 11, 2003
15	12	July 7, 2003	July 20, 2003	July 25, 2003
16	11	July 21, 2003	August 3, 2003	August 8, 2003
17	10	August 4, 2003	August 17, 2003	August 22, 2003
18	9	August 18, 2003	August 31, 2003	September 5, 2003
19	8	September 1, 2003	September 14, 2003	September 19, 2003
20	7	September 15, 2003	September 28, 2003	October 3, 2003
21	6	September 29, 2003	October 12, 2003	October 17, 2003
22	5	October 13, 2003	October 26, 2003	October 31, 2003
23	4	October 27, 2003	November 9, 2003	November 14, 2003
24	3	November 10, 2003	November 23, 2003	November 26, 2003*
25	2	November 24, 2003	December 7, 2003	December 12, 2003
26	1	December 8, 2003	December 21, 2003	December 24, 2003*

[Ä]Use the Mariflex column to estimate the number of pay periods left in the year when figuring your employee cost per payday. For example, if your benefits become effective on May 26, 2003, divide your total amount for the remainder of the calendar year by 15 to determine your cost per payday.

**MIHS employees will be paid on November 28, 2003 and December 26, 2003.*

2003 - 2004 HOLIDAY SCHEDULE

Holiday	*2003*	*2004*
New Year's Day	Wednesday, January 1	Thursday, January 1
Martin Luther King Jr./Civil Rights Day	Monday, January 20	Monday, January 19
Presidents' Day	Monday, February 17	Monday, February 16
Memorial Day	Monday, May 26	Monday, May 31
Independence Day	Friday, July 4	Monday, July 5
Labor Day	Monday, September 1	Monday, September 6
Columbus Day	Monday, October 13	Monday, October 11
Veteran's Day	Tuesday, November 11	Thursday, November 11
Thanksgiving Day	Thursday, November 27	Thursday, November 25
Christmas Day	Thursday, December 25	Friday, December 25

Who to Contact

Effective January 1, 2003

EMPLOYEE BENEFITS	PHONE	E-MAIL	WEB ADDRESS
Maricopa County Benefits Office Maricopa County Administration Building 301 West Jefferson Street, Suite 201 Phoenix, Arizona 85003-2145	602-506-1010 Fax 602-506-2354	benefitsservice@ mail.maricopa.gov	**Internet**: www.maricopa.gov/benefits **Intranet**: ebc.maricopa.gov/hr/benefits
MEDICAL PLANS			
CIGNA (HMO and POS) **CIGNA (PPO)**	800-244-6224 800-251-0669		www.cigna.com www.mycigna.com
HealthSelect Outside Phoenix	602-344-8760 800-582-8686		www.maricopa.gov/medcenter/healthplans
PHARMACY PLANS			
Walgreens Health Initiatives (WHI) (For ALL CIGNA Medical Plans) **WHI Clinical Prior Authorization** **Walgreens HealthCare Plus' Mail Order Member Service** **Mail Order Refills**	800-207-2568 (Member Services) 877-665-6609 888-265-1953 800-797-3345		www.whphi.com
HealthSelect Outside Phoenix	602-344-8760 800-582-8686		www.maricopa.gov/medcenter/healthplans
BEHAVIORAL HEALTH PLAN			
United Behavioral Health Included in HealthSelect and all CIGNA Medical plans	866-312-3078		www.ubhnet.com
VISION PLAN			
AVESIS (Included in HealthSelect and all CIGNA medical plans)	800-828-9341	info@avesis.com	www.avesis.com
DENTAL PLANS			
United Concordia	800-332-0366		www.ucci.com
Employer's Dental Service (EDS)	602-248-8912 800-722-9772		www.mydentalplan.net
UNUM LIFE INSURANCE AND SHORT TERM DISABILITY			
Short Term Disability	800-345-6495		
Life Customer Service	800-421-0344		www.unum.com
Life Conversion and Portability	800-343-5406		www.unum.com
Life Claims	800-445-0402		www.unum.com
OTHER IMPORTANT NUMBERS			
ASI: Mariflex Administrator	800-659-3035	asi@asiflex.com	www.asiflex.com
Nationwide Retirement Solutions: Deferred Compensation	602-266-2733 800-653-4632	askus@nationwide.com	nationaldeferred.nrsservicecenter.com/nrs
Liberty Mutual: Auto, Home, and Renters Insurance	800-221-8135		www.libertymutual.com/lm/maricopafcu
Trustmark: Critical Illness Coverage	480-991-4444, ext. 15	enrollment@einsteinbenefit.com	
ComPsych Guidance Resources: EAP	888-355-5385		
Arizona State Retirement System Outside of Phoenix	602-240-2000 800-621-3778		www.asrs.state.az.us
Public Safety Retirement System	602-255-5575		www.psprs.com